FEHBP: OPM'S POLICY GUIDANCE FOR FISCAL YEAR 2000

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CIVIL SERVICE

OF THE

COMMITTEE ON
GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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FEHBP: OPM'S POLICY GUIDANCE FOR FISCAL YEAR 2000

THURSDAY, MAY 13, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:20 a.m., in room 2154, Rayburn House Office Building, Hon. Joe Scarborough (chairman of the subcommittee) presiding.

Present: Representatives Scarborough, Morella, Cummings, Norton, and Allen.

Staff present: George Nesterczuk, staff director; Garry Ewing, counsel; John Cardarelli, clerk; Jeff Shea, professional staff member; Tania Shand, minority professional staff member; and Jean Gosa, minority staff assistant.

Mr. SCARBOROUGH. Good morning. I want to thank all of our witnesses for participating in this important hearing today.

My name is Joe Scarborough. I appreciate you being here, and I apologize for the delay. You all are experts on the Federal Employees Health Benefits Program. I'm sure the subcommittee is going to benefit greatly from your insights on the impact that OPM's policy guidance for the year 2000 will have on the FEHB and those who rely on it for their health care coverage.

The FEHB is the largest employer-sponsored health benefits program in the Nation. Approximately 9 million individuals, Federal employees, retirees and their families, obtain their health care insurance through the FEHB. In the eyes of Federal employees and the annuitants both, it is one of the most important benefits the Federal Government provides for active and retired civil servants.

Over the years, the FEHB has earned a widespread reputation as a model employer-sponsored health benefits program. Even now, many experts consider the FEHB a model for reforming Medicare.

Nevertheless, we've seen some disturbing developments in the direction of the FEHB in recent years. The development that's most visible I'm sure to individual enrollees is the dramatic premium increases during the last 2 years.

During that period, FEHB premiums have increased on average by 8.5 percent in 1998 and 10.2 percent in 1999. The President's budget appears to anticipate another double digit increase again for the year 2000.

We have also seen a trend toward more mandated benefits and an increased standardization in FEHB. I believe this development is a real threat to the FEHB. The key to the program's success has

been its market orientation. Consumers may choose the health plan that best meets their needs from among many competing offerings. That framework has made it possible for both employees and annuitants to receive high-quality health care coverage at reasonable premiums.

Mandates and standardization are incompatible with this successful approach. Now experts have been warned and have warned this subcommittee that mandates and overregulation of the FEHB market adds costs to the programs and reduces consumer choice. Mandates have both visible and hidden costs.

The visible cost, of course, is the added cost of providing the mandated benefit. The hidden cost results from the loss of flexibility that carriers should have to design the innovative benefit packages that will be both attractive to consumers and cost effective.

When viewed in isolation, however, the cost of providing a single benefit often appears very reasonable. But it's much harder to calculate the hidden, but very real, costs of the loss of flexibility and consumer choice. Each mandate creates its own cost spiral which in the aggregate is an engine for driving up premiums.

As the administrator of the FEHB, OPM also affects premiums and the quality of health care available to the employees and retirees through administrative directives and through other mandates.

For example, directives drawn from the President's self-titled patient's bill of rights such as information disclosure requirements and the right to demand amendments to one's medical records could really increase costs without providing benefits to enrollees.

On the other hand, if OPM provides carriers with sufficient flexibility to implement these instructions, their costs may at least be contained.

For these reasons, this subcommittee has a duty to carefully examine the directives in the call letter. In conducting this examination, I believe the following questions are critical.

First of all, does the policy directive address a real problem in the FEHB? Second, will the directive increase premiums or lower the quality of health care for Federal employees and retirees? Third, will the directive be implemented in a reasonable manner?

The answers to these questions are important to each person who relies on the FEHB, for the carriers who participate in the program, and finally for the taxpayers who will be shouldering the burden of paying for 72 percent of FEHB premiums.

I look forward to exploring these issues with each of our witnesses and again thank them for their cooperation in making this hearing possible.

Now it's certainly my privilege to turn it over to the ranking member, Mr. Cummings, for any comments that he may have.

[The prepared statement of Hon. Joe Scarborough follows:]

ONE HUNDRED SIXTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON GOVERNMENT REFORM

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OPENING STATEMENT
THE HONORABLE JOE SCARBOROUGH
CHAIRMAN
SUBCOMMITTEE ON CIVIL SERVICE

FEHBP: OPM's Policy Guidance for 2000

May 13, 1999

Good morning. I thank all of our witnesses for participating in this important hearing. You all are experts on the Federal Employees Health Benefits Program (FEHB). I am sure the subcommittee will benefit greatly from your insights on the impact that OPM's policy guidance for the year 2000 will have on the FEHB and those who rely on it for their health care coverage.

The FEHB is the largest employer-sponsored health benefits program in the nation. Approximately 9 million individuals - federal employees, retirees, and their families - obtain their health care insurance through the FEHB. In the eyes of federal employees and annuitants both, it is one of the most important benefits the federal government provides for active and retired civil servants. Over the years, the FEHB has earned a widespread reputation as a model employer-sponsored health benefits program. Even now, many experts consider the FEHB a model for reforming Medicare.

Nevertheless, we have seen some disturbing developments in the direction of the FEHB in recent years. The development most visible, I am sure, to individual enrollees is the dramatic premium increases in the last two years. During that period, FEHB premiums have increased, on average, by 8.5% in 1998 and 10.2% in 1999. The President's budget appears to anticipate another double-digit increase again in 2000.

We have also seen a trend toward more mandated benefits and increased standardization in the FEHB. This development is a real threat to the FEHB. The key to the program's success has been its market-orientation. Consumers may choose the health plan that best meets their needs from among many competing offerings. That framework has made it possible for both employees and annuitants to receive high-quality health coverage at reasonable premiums. Mandates and standardization are incompatible with this approach. Experts have warned this subcommittee that

mandates and overregulation of the FEHB market add costs to the program and reduce consumer choice.

Mandates have both visible and hidden costs. The visible cost, of course, is the added cost of providing the mandated benefit. The hidden cost results from the loss of flexibility that carriers should have to design innovative benefit packages that will be both attractive to consumers and cost effective. When viewed in isolation, however, the cost of providing a single benefit often appears very reasonable. But it is much harder to calculate the hidden, but very real, cost of the loss of flexibility and consumer choice. Each mandate creates its own cost spiral, which in the aggregate is an engine driving up premiums.

As the administrator of the FEHB, OPM also affects premiums and the quality of health care available to employees and retirees through administrative directives other than mandates. For example, directives drawn from the President's so-called Patient's Bill of Rights, such as information disclosure requirements and the right to demand amendments to one's medical records, could well increase costs without providing a commensurate benefit to enrollees. On the other hand, if OPM provides carriers with sufficient flexibility to implement such instructions, their costs may at least be contained.

For these reasons, this subcommittee has a duty to carefully examine the directives promulgated in the call letter. In conducting this examination, I believe the following questions are critical:

1. Does the policy directive address a real problem in the FEHB?

2. Will the directive increase premiums or lower the quality of health care for federal employees and retirees?

3. Will the directive be implemented in a reasonable manner?

The answers to these questions are important to each person who relies on the FEHB, for the carriers who participate in the program, and for the taxpayers who shoulder the burden of paying for 72% of FEHB premiums. I look forward to exploring these issues with each of our witnesses.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. Today's hearing has been convened so that the subcommittee can continue its close oversight of the Federal Employees Health Benefits Program, an essential benefit program for Federal employees and retirees. Specifically, we will seek to determine the nature of the guidance to be provided to participating health insurance plans by the Office of Personnel Management through its call letter for the 2000 contract year.

In addition, the subcommittee will seek to determine the impact on FEHBP of President Clinton's executive memorandum mandating compliance with the patient's bill of rights.

Much has occurred, however, since we held a similar hearing last March. This year's call letter requiring full disclosure in the use of provider discounts effectively implements H.R. 1836, the Federal Employees Health Care Protections Act, enacted by Congress last year.

Though OPM's Inspector General found no unethical conduct on the part of plans who arrange for provider discounts, the implementation of the act strengthens OPM's ability to use administrative sanctions against health care providers who seek to defraud and abuse the government's health benefits program.

In 1998, FEHB plans supported and implemented important consumer protections outlined in the patient's bill of rights. These included information disclosure, access to emergency care, access to obstetricians and gynecologists, and access to specialists for people with special care needs.

At last year's hearing, I stated that I applauded the expansion of these important benefits and protections, but that it must be understood that expansion does not come without a cost.

I am pleased that the cost of implementing these protections to date is less than 25 cents per enrollee.

Finally, I understand that there is some controversy over the application of cost accounting standards to FEHBP contracts. Cost accounting standards are designed to increase the uniformity and consistency with which cost accounting data is supplied by contractors to the government for the purposes of assisting in either negotiation, pricing, or administration of contracts.

CAS are applied to all contractors that perform under negotiated, cost-based pricing arrangements with the Federal Government in order to ensure that costs are properly allocated. Blue Cross and Blue Shield has raised concerns about the difficulties of implementation of CAS on FEHBP plan contracts and would like to extend section 518 of the Omnibus Appropriations Act of 1998 which exempts carrier contracts from the application of CAS.

The American Federation of Government Employees believes the FEHB contracts should be subject to CAS so agencies can ensure the accuracy of bills submitted by contractors. There is also a concern that premiums will increase if CAS are not applied to FEHBP contracts.

I am looking forward to testimony from OPM, Blue Cross and Blue Shield, and AFGE on the pros and cons of applying CAS to FEHBP contracts and to ultimately do what is in the best interest of enrollees.

I thank all of the witnesses for coming this morning to testify before the subcommittee, and I hope that you can shed some light on these very important issues.

Mr. SCARBOROUGH. Thank you, Mr. Cummings.

[The prepared statement of Hon. Elijah E. Cummings follows:]

STATEMENT OF CONGRESSMAN ELIJAH CUMMINGS AT

A CIVIL SERVICE SUBCOMMITTEE HEARING

ON FEHBP: OPM'S POLICY GUIDANCE FOR FY 2000

Thursday, May 13, 1999

Mr. Chairman, today's hearing has been convened so that the Subcommittee can continue its close oversight of the Federal Employee Health Benefits Program (FEHBP) -- an essential benefit program for federal employees and retirees. Specifically, we will seek to determine the nature of the guidance to be provided to participating health insurance plans by the Office of Personnel Management (OPM) through its Call Letter for the 2000 Contract Year. In addition, the Subcommittee will seek to determine the impact on FEHBP of President Clinton's Executive Memorandum mandating compliance with the Patients' Bill of Rights.

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I am looking forward to testimony from OPM, Blue Cross-Blue Shield, and AFGE on the pros and cons of applying CAS to FEHBP contracts, and to ultimately do what is in the best interest of enrollees.

I thank all of the witnesses for coming this morning to testify before the Subcommittee and I hope that you can shed some light on these very important issues.

Mr. SCARBOROUGH. Mrs. Morella.

Mrs. MORELLA. Thank you, Mr. Chairman. And I also appreciate your holding this oversight hearing to discuss the administration of the Federal Employees Health Benefits Program. Like many of my constituents, I was shocked last fall when I learned that, on average, premiums in the program would rise by 10.2 percent in 1999. Within this overall rise in premiums, there was an average increase of 7.4 percent in the employee and retiree share of the FEHBP premiums.

As before, I'm concerned that the magnitude of this increase was so far above the 3.5 percent rate of medical inflation, and I must point out that an article in the journal Health Affairs reported last year that premiums in private employer-sponsored health plans would rise at the considerably slower rate of 3.3 percent in 1999. How will this discrepancy affect the increase, if any, of the premiums in the year 2000?

In particular, I think we need to discuss the specific cost increases and efforts being made to avoid or to limit them. For instance, last year it was reported that prescription drug costs, which account for approximately 20 percent of FEHBP expenditures, would rise by as much as 22 percent. According to the Employee Benefit Research Institute, private insurance payments for prescription drugs increased 17.7 percent in 1997, after growing 22.1 percent in 1995 and 18.3 percent in 1996.

FEHBP is the country's largest employer-based health insurance program serving the health care needs of almost 10 million Federal employees, retirees and their families. And basically I think it's a good program.

But how are FEHBP's plans using this leverage to implement meaningful cost containment mechanisms with the goal of passing on the savings to plan members?

Further, a leading explanation for the sharp growth in drug expenditures is that prescription drugs are a substitute for other forms of health care. The theory is that using pharmaceutical products will result in cost savings in other areas of the program.

For example, last year I was active in the passage of legislation requiring all but five religious-based FEHBP plans to cover all five methods of prescription contraceptives. Previously, only 19 percent of Federal health plans covered all five methods.

And while it's difficult to determine the extent to which these contraceptives save the health plans money by protecting women's health, preventing unintended pregnancies and reducing abortions, I'm interested in learning more on the implementation and the impact of this provision.

On a related note, I'm curious how other preventative measures like ensuring consistent coverage of bone density tests through a comprehensive national coverage policy in the FEHBP would reduce future costs to the program.

And, finally, I'm also interested in hearing about those steps that are being taken to ensure uninterrupted complete service to all plan participants in light of Y2K. I understand that carriers are required to report on their Y2K compliance status along with their

benefit and rate proposals on May 31st. At this point, what can the witnesses tell us about their progress in assuring Y2K compliance?

I thank you, Mr. Chairman. I look forward to hearing the panelists and I yield back.

[The prepared statement of Hon. Constance A. Morella follows:]

Statement of the Honorable Constance A. Morella
Civil Service Subcommittee Hearing
FEHBP Policy Guidance for 2000
May 13, 1999

Mr. Chairman, I thank you for holding this oversight hearing to discuss the administration of the Federal Employees Health Benefits Program. Like many of my constituents, I was shocked last Fall when I learned that, on average, premiums in the program would rise by 10.2 percent in 1999. Within this overall rise in premiums, there was an average increase of 7.4 percent in the employee and retiree share of FEHBP premiums.

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discrepancy affect the increase, if any, if premiums in the year 2000?

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Further, a leading explanation for the sharp growth in drug

expenditures is that prescription drugs are a substitute for other forms of health care. The theory is that using pharmaceutical products will result in cost savings in other areas of the program. For example, last year I was active in passing legislation requiring all but five religious-based FEHBP plans to cover all five methods of prescription contraceptives: the pill, diaphragm, IUDs, Norplant, and Depo-Provera. Previously, only 19 percent of federal health plans covered all five methods of prescription contraceptives. While it is difficult to determine the extent to which these contraceptives save the health plans money by protecting women's health, preventing unintended pregnancies, and reducing abortions, I am interested in hearing more on the implementation and impact of this provision.

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Mr. SCARBOROUGH. I thank Mrs. Morella. Mrs. Morella is a champion of the rights of Federal employees and we certainly appreciate her help and participation on the committee, as we do Mr. Cummings and obviously also Ms. Norton.

I would like to recognize Ms. Norton for any opening statement she may have.

Ms. NORTON. Thank you, Mr. Chairman. And I appreciate your views of the occasion of the issuance of OPM's annual call letter inviting proposals for the change in rates and benefits to do oversight on the very important, perhaps the most important program for Federal employees, the Federal Employees Health Benefits Program.

I think that I can say without contradiction that the FEHBP works better than many health plans in the country. That does not mean that this plan is anywhere close to perfect; and, therefore, the opportunity to look more closely at how to improve it, should in fact be welcome.

The concern about costs abated for a while, because costs slowed considerably during the early 1990's, and now we are back where we were with costs going up very rapidly.

And one is almost left to believe that companies were inclined to control costs during the time when the President's comprehensive health plan was being passed that at least it had a deterrent effect on costs, because when that bill died, almost on cue, we began to see costs going up again.

Now, I would be the first to admit that there are other factors in the marketplace, but I am very concerned that costs for the FEHBP which had done a good job in controlling costs have begun now to keep pace and exceed costs elsewhere, without, it seems to me, a credible explanation.

I note that there has been some objection to President Clinton's Executive order implementing a patient's bill of rights. I just think that's a pitiful way to try to account for costs increases, particularly, since what the President's modest version of a patient's bill of rights did was essentially sanction the plans already allowed—virtually all of the controversial differences between the Democrat and Republican bills in the House and Senate are not even in the Executive order, and some of them couldn't be in the Executive order in any case because you can't do them in Executive orders.

So I will be looking this morning for some serious discussion about costs and why costs are going up from FEHBP and from the carriers who are here. If you're serious about costs, you've got to look beyond whatever small costs come out of something like a patient's bill of rights and get down to real explanations about why these costs began to go up again during the mid and late 1990's while you were able to hold them down in the early 1990's.

These costs are not simply borne by the taxpayers, they are also borne by employees. The taxpayers deserve a credible explanation and so do Federal employees.

Thank you very much, Mr. Chairman.

Mr. SCARBOROUGH. I thank you, Ms. Norton. Now we will hear from our friend from Maine.

Mr. ALLEN. Mr. Chairman, I simply want to thank you for holding this hearing and state that I look forward to hearing the testi-

mony of all of the witnesses. And I appreciate your being here today. It's no secret I have a special interest in the rapid increase in the price of and utilization of prescription drugs, and I think that if we can understand how prescription drug prices are affecting the Federal Employees Health Benefits Program, we will have a better sense for how that issue is affecting Medicare beneficiaries and others in private plans throughout the country.

So I appreciate your holding this hearing, Mr. Chairman. Thank you.

Mr. SCARBOROUGH. Well, thank you, Mr. Allen.

Now we're ready for our first panel. We ask William E. Flynn III, Ed Flynn, who is the Associate Director of Retirement and Insurance Services in the Office of Personnel Management to please come forward—and, as you know, going through this routine quite a few times since this is an investigative committee, we ask that you raise your right hand and take the oath.

[Witness sworn.]

Mr. SCARBOROUGH. Thank you. If you could be seated and please give us your opening statement.

STATEMENT OF WILLIAM E. FLYNN III, ASSOCIATE DIRECTOR, RETIREMENT AND INSURANCE SERVICES, OFFICE OF PERSONNEL MANAGEMENT

Mr. FLYNN. Thank you, Mr. Chairman. Good morning to all the members of the subcommittee. I do want to thank you for inviting me today to discuss OPM's goals for negotiations later this summer with health plans that participate with us in the Federal Employees Health Benefits Program. At the outset, I would like to say that we are confident that the objectives we're pursuing will strengthen our ability to provide high quality affordable health care for the 9 million individuals we cover.

In addition, the program will remain a model employer-sponsored program that relies on competition and consumer choice. As importantly, we value greatly the opportunity to partner with the almost 300 health plans which play a vital role in insuring the program's success. Quite honestly, we couldn't offer the program without them. As one example, over the past 2 years in collaboration with health plans, we've undertaken full implementation of President Clinton's patient's bill of rights.

For total costs of less than $10 annually for each policyholder, participants in the program this year will have greater access to care, emergency rooms, and from specialists when needed and more information enabling them to make informed health care choices.

For contract year 2000, which will begin next January, we have focused our objectives in the following areas: further work on implementation of the President's patient's bill of rights, quality measures for health care, family-centered health care, enhancements in customer service, clarifications in provider contracts, implementation of the Department of Defense's demonstration project involving the Federal Employees Health Benefits Program, and Y2K or year 2000 compliance.

Now, in the remaining few minutes, Mr. Chairman, I would like to point to a few items which I believe can help set a context for our discussions today. First, we are as concerned as anyone over

the rising costs of health care. The Federal Employees Health Benefits Program is a market-based program, and testimony at last fall's hearing aptly demonstrated that the cost increases we were experiencing were being driven by the same forces, and generally at the same levels, as other parts of the health care economy.

The total average premium in the program today is about $4,400 per year. In an era of managed care and some of the problems that it has generated, investing $10 per year in safeguards, information and other protections associated with the patient's bill of rights seems a prudent investment.

This is particularly so given our emphasis on results in a setting where we rely on health plans to install procedures which are appropriate for their individual business settings.

Second, I think it's important to constantly reinforce the idea that this program is an important component of the compensation package which the government offers in order to attract and retain the kinds of employees necessary to carry out the work of government. For that reason, we must always stay attuned to what our customers tell us.

We undertake extensive efforts to do that, some of which led to the objectives outlined in the call letter. Nonetheless, we can always do better. I am concerned when I hear that important participants in this program believe that their views are not being heard.

However that belief has come to be held, it's harmful and I'm confident we can and will overcome it.

And finally all of us are interested in holding costs down or perhaps even reducing them. Most commentators believe that the savings which resulted from the widespread introduction of managed care have now been achieved and are not likely to be repeated except at the margin.

In this context, it's entirely reasonable to carefully examine alternative means of achieving savings. And I believe two areas hold particular promise.

The first can be found in the increasing volume of knowledge about health care quality and techniques that produce healthy outcomes. In the few short years I've been associated with this program, there have been remarkable advances in the collection, analysis, and dissemination of data about treatments that are effective and cost efficient. We should do more.

And second, we have seen how the creation of preferred provider networks has helped control costs in the Federal Employees Health Benefits Programs. Those networks are widely offered within each of the health plans that participate. It's only reasonable to suppose that aggregations of networks which can take several different forms might be further effective in controlling costs into the future.

In short, Mr. Chairman, there are things which can and should be considered and discussion of them should be inclusive. We can't afford to simply assume that things will take care of themselves. And we look forward to working with you and other members of the committee and others on these important matters. Thank you.

[The prepared statement of Mr. Flynn follows:]

STATEMENT OF
WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
U.S. OFFICE OF PERSONNEL MANAGEMENT

at an oversight hearing of the

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

on

OPM'S POLICY GUIDANCE FOR FEHB CONTRACT YEAR 2000

May 13, 1999

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR INVITING ME TODAY TO DISCUSS OPM'S GOALS FOR UPCOMING CONTRACT NEGOTIATIONS WITH HEALTH PLANS ELIGIBLE TO PARTICIPATE IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM DURING THE YEAR 2000.

SPECIFICALLY, YOU HAVE ASKED HOW THE POLICIES OPM COMMUNICATED TO HEALTH PLANS IN LAST MONTH'S CALL LETTER INVITING PROPOSALS FOR RATE AND BENEFIT CHANGES WILL IMPACT PREMIUM RATES AND THE QUALITY OF BENEFITS CURRENTLY AVAILABLE. WE ARE CONFIDENT THAT THE PROGRAM WILL MAINTAIN ITS ABILITY TO PROVIDE HIGH-QUALITY, AFFORDABLE HEALTH CARE FOR ITS APPROXIMATELY 9 MILLION MEMBERS. IN ADDITION, IT WILL REMAIN AS A MODEL EMPLOYER-BASED HEALTH BENEFITS PROGRAM THAT RELIES ON COMPETITION AND CONSUMER CHOICE.

IN ISSUING THE CALL LETTER EACH YEAR, OUR PURPOSE IS TO COMMUNICATE OPM'S EXPECTATIONS FOR CONTRACTING OUTCOMES. OUR GUIDANCE LEAVES AS MUCH FLEXIBILITY AS POSSIBLE FOR EACH PLAN TO MAKE PROPOSALS THAT WILL ACHIEVE THE DESIRED OUTCOMES FOR ENROLLEES. ACCORDINGLY, EACH HEALTH PLAN'S BENEFITS AND RATES ARE ULTIMATELY THE PRODUCT OF BILATERAL NEGOTIATIONS. OPM VALUES THIS OPPORTUNITY TO PARTNER WITH HEALTH INSURERS TO OFFER ENROLLEES ACCESS TO QUALITY CARE AT AFFORDABLE RATES.

AS A RESPONSIBLE EMPLOYER-SPONSOR OF A HEALTH INSURANCE PROGRAM, OPM'S ADMINISTRATION OF THE PROGRAM HAS BEEN, AND WILL CONTINUE TO BE, PROGRESSIVE. MANY OF THE IMPROVEMENTS WE HAVE CHAMPIONED HAVE BEEN ACHIEVED WITH MINIMAL, IF ANY IMPACT ON PREMIUMS. SINCE THE EARLY 1990'S, WE HAVE ENSURED THAT ALL PLANS INCLUDE A COMPREHENSIVE CORE OF MEDICAL BENEFITS, SO THAT PARTICIPANTS CAN BE ASSURED OF COVERAGE FOR BASIC HEALTH NEEDS. ALL PLANS NOW INCLUDE MECHANISMS TO MANAGE CARE WITHOUT JEOPARDIZING QUALITY. WE HAVE CONTINUALLY IMPROVED INFORMATION AND RELATED MATERIALS TO ENCOURAGE PARTICIPANTS TO BE INFORMED CONSUMERS. MORE RECENTLY, WE HAVE ENCOURAGED HEALTH PLANS TO BECOME ACCREDITED. OVER THE PAST TWO YEARS, IN COLLABORATION WITH CARRIERS, WE HAVE UNDERTAKEN FULL IMPLEMENTATION OF PRESIDENT CLINTON'S PATIENTS' BILL OF RIGHTS.

FOR A TOTAL COST OF LESS THAN $10 PER YEAR FOR EACH POLICYHOLDER,

PARTICIPANTS IN THE PROGRAM RECEIVE A BROAD RANGE OF PROTECTIONS.

FOR 1999, WE ADDED THE FOLLOWING:

- USE OF THE "PRUDENT LAYPERSON" STANDARD FOR ACCESSING EMERGENCY CARE;
- DIRECT ACCESS TO QUALIFIED PROVIDERS FOR ROUTINE AND PREVENTIVE WOMEN'S HEALTH SERVICES;
- DIRECT ACCESS TO SPECIALISTS FOR PEOPLE UNDERGOING TREATMENT PLANS;
- ACCESS TO NEEDED SPECIALISTS, EVEN IF THEY ARE OUTSIDE OF THE PLAN'S NETWORK; AND
- MANY IMPORTANT PATIENT PROTECTIONS SURROUNDING INFORMATION DISCLOSURES ON PLAN CHARACTERISTICS AND PERFORMANCE, PROVIDER NETWORK CHARACTERISTICS, AND CARE MANAGEMENT.

THE SIGNIFICANT CONTRACTING INITIATIVES OPM IDENTIFIED FOR CONTRACT

YEAR 2000 INCLUDE:

- THE PATIENTS' BILL OF RIGHTS;
- QUALITY HEALTHCARE;
- MORE FAMILY-CENTERED HEALTHCARE;
- ENHANCED CUSTOMER SERVICE;
- CLARIFYING PROVIDER CONTRACTS;
- IMPLEMENTATION OF THE DOD/FEHB DEMONSTRATION PROJECT; AND
- Y2K COMPLIANCE.

PATIENTS' BILL OF RIGHTS

THE 1999 CALL LETTER INCLUDES TWO ENCLOSURES THAT SUMMARIZE

INFORMATION DISCLOSURES AND BENEFIT CHANGES PLANS SHOULD ALREADY

HAVE IN PLACE FOR 1999, AND NEW DISCLOSURES AND BENEFITS FOR YEAR 2000 CONTRACTS. WE EXPECT THE PROGRAM-WIDE COST OF IMPLEMENTING THE REMAINING FEATURES WILL BE SMALL, AS PLANS HAVE PREVIOUSLY COMPLETED MANY OF THE REQUIREMENTS.

DURING NEGOTIATIONS THIS SUMMER, OPM WILL WORK WITH EACH PLAN TO DEVELOP BROCHURE LANGUAGE THAT DESCRIBES THE INFORMATION PLAN MEMBERS ARE ENTITLED TO RECEIVE—WHETHER IN ADVANCE OF ENROLLMENT DECISIONS OR UPON REQUEST—AND THE MEANS FOR ACCESSING IT. OUR GOAL IS TO HAVE A POSITIVE IMPACT ON CARE BY ENABLING INDIVIDUALS TO MAKE BETTER PLAN COMPARISONS AND TO ASSESS PROVIDER QUALIFICATIONS AND AVAILABLE TREATMENT OPTIONS.

LAST YEAR'S CALL LETTER RECOGNIZED THAT CERTAIN PATIENTS' BILL OF RIGHTS BENEFIT CHANGES MIGHT REQUIRE CHANGES THAT PLANS COULD NOT IMMEDIATELY EFFECT. ACCORDINGLY, OPM IS NOW ASKING PLANS TO SPECIFY COMPLIANCE STRATEGIES FOR TRANSITIONAL CARE. THIS BENEFIT PROTECTS PLAN MEMBERS UNDERGOING TREATMENT FOR CHRONIC OR DISABLING CONDITIONS (OR IN THE SECOND OR THIRD TRIMESTER OF PREGNANCY) AT THE TIME THEY INVOLUNTARILY CHANGE HEALTH PLANS, OR AT THE TIME THEIR PROVIDER IS TERMINATED BY THE PLAN FOR REASONS OTHER THAN CAUSE. IT ALLOWS PLAN MEMBERS TO CONTINUE SEEING THEIR SPECIALTY PROVIDERS

FOR UP TO 90 DAYS (OR THROUGH COMPLETION OF POSTPARTUM CARE) AT THE SAME COST THE MEMBER WAS INCURRING PREVIOUSLY. ALSO, HEALTH PLANS MUST ESTABLISH PROCEDURES TO ALLOW PATIENTS TO REVIEW AND OBTAIN COPIES OF THEIR MEDICAL RECORDS ON REQUEST AND REQUEST THAT A PHYSICIAN AMEND, OR ALLOW THEM TO APPEND, A RECORD THEY BELIEVE IS INACCURATE, IRRELEVANT, OR INCOMPLETE.

QUALITY HEALTHCARE

QUALITY HEALTHCARE REFERS TO THE DEGREE TO WHICH HEALTH SERVICES FOR INDIVIDUALS AND POPULATIONS INCREASE THE LIKELIHOOD OF DESIRED HEALTH OUTCOMES AND ARE CONSISTENT WITH CURRENT PROFESSIONAL KNOWLEDGE. MOREOVER, NOW THAT EVERY TYPE OF HEALTH PLAN USES MECHANISMS TO MANAGE UTILIZATION, QUALITY HEALTHCARE MUST ALSO ENCOMPASS HOW A PLAN MEETS ITS MEMBERS' NONCLINICAL NEEDS AND EXPECTATIONS. PLAN PERFORMANCE MEASUREMENTS BOLSTER MARKET COMPETITION AND INFORMED CHOICE. OUR CALL LETTER LISTS QUALITY ASSESSMENT METHODS ON WHICH OPM EXPECTS HEALTH PLAN COOPERATION, INCLUDING:

- STRONGLY ENCOURAGING PLANS TO SEEK ACCREDITATION FROM AN EXTERNAL ORGANIZATION;
- ASKING PLANS THAT REPORT ON STANDARDIZED PERFORMANCE MEASURES IN THE HEALTH PLAN AND EMPLOYER DATA INFORMATION SET (HEDIS) FOR OTHER PURCHASERS, TO SHARE REPORTS WITH OPM IN 2000; OPM MAY ASK NON-REPORTING PLANS TO REPORT HEDIS-LIKE

DATA;

- ASKING HEALTH PLANS TO PARTICIPATE IN OUTCOME MEASURES RESEARCH SUCH AS THE ASTHMA TREATMENT PROJECT THAT OPM CONDUCTED IN COOPERATION WITH SEVERAL HEALTH PLANS AND THE FOUNDATION FOR ACCOUNTABILITY (FACCT); AND
- CONTINUING USE OF THE CONSUMER ASSESSMENT OF HEALTH PLANS STUDY (CAHPS) ADULT AND CHILD QUESTIONNAIRES, UNDER NATIONAL COMMISSION FOR QUALITY ASSURANCE (NCQA) PROTOCOLS, TO MEASURE FEHB CUSTOMER SATISFACTION.

FAMILY-CENTERED CARE

LAST YEAR, THE VICE PRESIDENT'S 7TH ANNUAL FAMILY REUNION FOCUSED ON FAMILIES AND HEALTH. AS A PARTICIPANT IN THAT EVENT, THE INSTITUTE FOR FAMILY-CENTERED CARE PROMOTED THE IDEA THAT THE FAMILY HAS SIGNIFICANT INFLUENCE OVER AN INDIVIDUAL'S HEALTH AND WELL-BEING AND, THEREFORE, FAMILIES MUST BE SUPPORTED IN THEIR ROLES AS CARE GIVERS AND DECISION MAKERS. THIS INSPIRED A DISCUSSION OF FAMILY-FOCUSED HEALTH CARE AT THE FEHB CARRIER CONFERENCE LAST FALL AND ULTIMATELY OPM CONTRACTED WITH THE GALLUP ORGANIZATION TO CONDUCT FOCUS GROUPS IN SEVERAL LARGE CITIES TO ASSESS OUR PROGRAM FROM A FAMILY-FOCUSED PERSPECTIVE.

FOLLOWING UP ON THESE INITIATIVES, THE CALL LETTER EXPLAINS THAT OPM EXPECTS HEALTH PLANS NOT ONLY TO FOLLOW RECOMMENDATIONS OF RECOGNIZED MEDICAL AUTHORITIES CONCERNING CHILDHOOD

IMMUNIZATIONS AND HEALTH SCREENINGS BUT ALSO TO CONSIDER RISK ASSESSMENT AND FAMILY HISTORY WHEN MAKING COVERAGE DETERMINATIONS. NOTING THE WIDE INTEREST IN DENTAL AND VISION COVERAGE, OPM URGES PLANS TO OFFER COVERAGE TO FEHB MEMBERS AS NON-FEHB BENEFITS WHILE OPM LOOKS AT OPTIONS IN THESE AREAS FOR THE FUTURE. IN RESPONSE TO ISSUES FOCUS GROUPS RAISED ABOUT PLAN ADMINISTRATION, WE ENCOURAGE PLANS TO PLAY A POSITIVE ROLE AS FACILITATOR IN BEHALF OF THEIR MEMBERS AND TO DEVELOP REFERRAL PROCEDURES THAT MINIMIZE DISRUPTION TO ENROLLEES. WE SUGGEST THAT WELL-ESTABLISHED PATIENT EDUCATION PROGRAMS AND CLEARLY WRITTEN BENEFIT EXPLANATIONS MAY PROMOTE MORE REALISTIC MEMBER EXPECTATIONS. FAMILY-CENTERED CARE TAKES A COLLABORATIVE EFFORT BETWEEN THE PATIENT, PROVIDER, AND HEALTH PLAN. OPM INVITES EVERY PLAN TO REPORT ACTIVITIES IN THIS AREA AND TO SUBMIT EXAMPLES OF FAMILY-CENTERED COMMUNICATIONS FOR ENROLLEES.

CUSTOMER SERVICE

THE PRESIDENT AND VICE PRESIDENT HAVE MADE PLAIN LANGUAGE IN GOVERNMENT WRITING A TOP PRIORITY FOR FEDERAL AGENCIES. IT SAVES TIME, EFFORT, AND MONEY, AND SENDS A CLEAR MESSAGE ABOUT WHAT THE GOVERNMENT IS DOING. IN JANUARY, OPM ANNOUNCED AN INITIATIVE TO REWRITE HEALTH PLAN BROCHURES IN PLAIN LANGUAGE AND, IN

COLLABORATION WITH HEALTH PLAN REPRESENTATIVES, IS DEVELOPING GUIDELINES FOR WRITTEN COMMUNICATIONS. PLANS CAN ANTICIPATE THESE PRODUCTS IN LATE SPRING. WE ARE VERY EXCITED ABOUT THIS PROJECT. IT WILL IMPROVE THE CLARITY OF OUR BROCHURES AND RELATIONSHIPS WITH CUSTOMERS.

THE SECOND ITEM UNDER CUSTOMER SERVICE ADDRESSES DEFICIENCIES BY SOME PLANS IN PROCESSING ELECTRONIC ENROLLMENTS LAST YEAR. WE REQUIRE THAT PARTICIPATING PLANS HAVE THE CAPABILITY TO PRODUCE BROCHURES, TO RECEIVE AND SEND ELECTRONIC INFORMATION, AND ACCEPT ENROLLMENT INFORMATION ELECTRONICALLY. THE GUIDANCE STRESSES THAT THE ABILITY TO MEET THESE REQUIREMENTS IS AN IMPORTANT ELEMENT IN EVALUATING A PLAN'S PERFORMANCE.

PROVIDER CONTRACTS

THIS SECTION OF THE CALL LETTER CLARIFIES TWO ISSUES RELATING TO PROVIDER REIMBURSEMENT UNDER FEE-FOR-SERVICE HEALTH PLANS. THERE HAS BEEN ON-GOING CONCERN IN THE MEDICAL COMMUNITY ABOUT PAYMENT SCHEMES THAT CREATE FEE DISCOUNTS FOR PAYERS WHO ARE NOT ENTITLED TO THEM. AN INVESTIGATION BY OPM'S INSPECTOR GENERAL FOUND NO EVIDENCE OF THESE PRACTICES IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM. NEVERTHELESS, WE EXPECT PLANS THAT SECURE FEE DISCOUNTS

THROUGH INTERMEDIARIES WILL CONTINUE TO ENSURE THAT DISCOUNTS ARE CONSISTENT WITH CONTRACTS BETWEEN THE VENDOR AND PROVIDER NETWORKS, AND ARE PROPERLY DISCLOSED.

THE SECOND ISSUE INVOLVES A PROVISION IN LAW THAT GUARANTEES ACCESS TO CERTAIN NON-PHYSICIAN PROVIDERS WHO ARE QUALIFIED TO RENDER A COVERED SERVICE. PUBLIC LAW 105-266 AMENDED THIS LAW TO CLARIFY THAT NOTHING PREVENTS HEALTH PLANS FROM PROVIDING BENEFITS FOR SERVICES RENDERED BY PROVIDERS OTHER THAN THOSE LISTED IN STATUTE. WE ENCOURAGE PLANS TO PROVIDE ACCESS TO NON-PHYSICIAN PROVIDERS WHO ARE QUALIFIED TO PROVIDE COVERED SERVICES, SUCH AS AUDIOLOGISTS OR PHYSICIAN ASSISTANTS, WHEN IT IS APPROPRIATE AND COST EFFECTIVE TO DO SO.

DOD/FEHB DEMONSTRATION PROJECT

THE CALL LETTER REMINDS PLANS THAT WE ARE IMPLEMENTING A DEMONSTRATION PROJECT THAT WILL PERMIT UP TO 66,000 MEDICARE-ELIGIBLE MILITARY RETIREES AND RELATED BENEFICIARIES TO ENROLL IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM BEGINNING IN JANUARY 2000, AND CONTINUING THROUGH THE END OF 2002. THE PROJECT WILL INVOLVE ALL OPEN FEE-FOR-SERVICE PLANS AND HMOS THAT OPERATE WITHIN THE EIGHT DEMONSTRATION SITES. AFFECTED HEALTH PLANS WILL ESTABLISH SEPARATE

RISK POOLS FOR MILITARY ENROLLEES, AND WILL SUBMIT A SEPARATE PREMIUM PROPOSAL FOR THE MILITARY GROUP. BENEFITS WILL BE THE SAME.

Y2K COMPLIANCE

THE CALL LETTER REMINDS PLANS THAT THE 1999 CONTRACT REQUIRES PLANS TO REPORT Y2K COMPLIANCE STATUS ALONG WITH THEIR BENEFIT AND RATE PROPOSALS ON MAY 31, 1999. WE FURTHER ADVISE PLANS THAT THEY SHOULD ANTICIPATE INCREASED DEMANDS BECAUSE OF PARTICIPANT APPREHENSION ABOUT THE YEAR 2000, AND TO TAKE STEPS TO ALLAY CONSUMER CONCERNS. WE EXPECT PLANS WILL HAVE PROCEDURES IN PLACE TO RELAX USUAL RESTRICTIONS ON ACCESS TO PRESCRIPTION REFILLS AND OTHER SERVICES.

THIS CONCLUDES MY OVERVIEW OF THE OBJECTIVES WE HOPE TO ACHIEVE FOR CONTRACT YEAR 2000. THE ANSWERS TO THE QUESTIONS CONTAINED IN THE LETTER INVITING MY TESTIMONY ACCOMPANY THIS STATEMENT. I WILL BE GLAD TO ANSWER OTHER QUESTIONS YOU HAVE NOW.

FEHBP: OPM's POLICY GUIDANCE FOR 2000
QUESTIONS AND ANSWERS
TO CIVIL SERVICE SUBCOMMITTEE
LETTER OF MAY 3, 1999

1. **Q.** The actual total cost, expressed on an annual basis, of implementing those parts of the President's Patient's Bill of Rights (PBOR) actually implemented last year, identifying separately the total annual cost of implementing OPM mandates for information disclosure, direct access to gynecologists, 90-day continuation of coverage, and providing access to non-network providers at network rates when insufficient specialists are in a plan's network.

   A. The total value of the PBOR is estimated at $33.5 million:
   Information disclosure - $17.5 million
   Direct access to gynecologists - $2.9 million
   90-day continuation of coverage - $3.8 million (scheduled for 2000)
   Direct access to non-network providers - $8.3 million
   Dispute resolution - $1 million.

   While the value of PBOR was estimated at $33.5 million, the actual cost incurred was much less. This is because most plans already had many of the required features, e.g., dispute resolution, in place or could easily adapt current policies and procedures to meet PBOR requirements. Indeed, only a handful of carriers sought an explicit rating adjustment and the total adjustment made for 1999 was less than $250,000.

2. **Q.** The actual total cost, expressed on an annual basis, of implementing OPM mandated coverage of pharmacotherapy.

   A. The increased cost for implementing coverage of pharmacotherapy associated office visits as a medical expense in 1999 was $6.4 million. This does not include the current expenses for plans that were already doing so at the time of negotiations.

3. **Q.** The estimated total cost, expressed on an annual basis, of implementing those aspects of the PBOR that OPM is mandating for contract year 2000, identifying separately the total annual cost of implementing OPM mandates for information disclosure, transitional care, and medical records.

   A. The estimated cost for transitional care is $3.8 million. This is the only aspect of year 2000 PBOR activities which is expected to have a cost.

4. **Q.** For each item identified under the headings, "Quality Healthcare," "Family Centered Care," and "Customer Service," in the April 9, 1999 call letter, provide the following:

b. An estimate of the total annual cost of implementing OPM's mandate or recommendation with respect to that item.

A. The items you identify do not represent problems that must be addressed. They highlight opportunities to improve the already high quality of services provided under the FEHB Program.

Quality Healthcare

OPM works closely with other government agencies, large employers in the private sector, professional health care organizations and associations, and FEHB members to assure that services provided under the Program meet accepted industry standards. This is part of an ongoing collaborative effort to refine the tools for measuring accountability. As a result, OPM and other health care purchasers will be able to provide continually improving information to help our employees make decisions about their choice of a health plan.

The specific tools referenced in the Call Letter, accreditation, HEDIS, outcome measures, and the CAHPS survey are all generally recognized measures of quality healthcare. Some are already in use in the FEHB Program. Others we intend to implement in close collaboration with our participating carriers.

There is no estimated cost associated with this initiative. However survey costs have always been an allowable expense.

Family-Centered Care

In support of the Administration's focus on Family-Centered Care, we had the Gallup Organization conduct focus groups with employees to determine what features and services were important to our families. Most of the benefit areas identified are already covered by some or all plans in the FEHB Program. Where enrollees suggested a benefit enhancement would significantly increase plan costs, such as dental and vision coverage, we asked participating carriers to offer that benefit as a non-FEHB benefit to our enrollees and to clearly communicate such information in their plan brochures.

Several items in the family-centered care category are updates to standard preventive services based on the most recent recommendations of various medical organizations with respect to screening procedures.

The cost of additional screenings is estimated at $12 million.

Customer Service

The Plain Language initiative was undertaken jointly with the carriers. The process of rewriting some of the standard administrative language in the plan brochures has already been completed successfully. The next step will involve rewriting the benefit descriptions so that enrollees will be better able to understand their coverage. Working with a representative group of carriers, we also have developed plain language guidelines to ensure that all communication with our customers from both the agency and the carriers gives them the information they need in language that is clear and concise.

The Electronic Enrollment section reinforces the need for all of carriers to be proficient in electronic communication. In 1998, there were a number of smaller plans with small FEHB enrollments that were not able to process employee and annuitant electronic enrollments. This problem has since been corrected. However, as agencies move away from paper transactions into a more efficient electronic mode, we want to make sure that all of our carriers are positioned to participate in that process.

There is no estimated cost associated with this initiative.

5. **Q.** Will OPM attempt to negotiate coverage of any benefit or service that has not been specifically identified in the April 9, 1999 call letter? If so, what benefit or services?

   A. Because the healthcare environment is not static, it is impossible to say with absolute certainty that nothing will happen before the end of contract negotiations that might change our view. However, as of now, we do not intend to negotiate for any benefit or service program-wide that has not been identified as an initiative in our 1999 call letter. This does not preclude routine negotiations on any given plan's benefits package.

6. **Q.** Did OPM fully implement in contract year 1999 each aspect of the PBOR that it originally intended to? If not, explain which provisions were not fully implemented and why.

   A. Yes.

7. **Q.** The President's Budget for Fiscal Year 2000 (Appendix, p. 1075) estimates that contributions from employees and annuitants will grow by 12.6% and 14%, respectively, between 1999 ad 2000. Does OPM expect FEHBP premiums for 2000 to increase? If so, by what amount does OPM? What factors does OPM believe will cause such an increase?

   A. The numbers you used came from lines in the President's Budget that represent total income to the FEHB fund in FY 1999 and FY 2000. Because these are income

totals, the increases are due in part to changes in population assumptions. For example, we assume there will be more annuitants in FY 2000 than in FY 1999.

Further, these numbers are based on fiscal years rather than FEHB contract years which are calendar years. Consequently, FY 1999 reflects partial 1998 and 1999 contract years and FY 2000 reflects partial 1999 and 2000 contract years.

While we expect an increase in premiums for the coming year, we will not know what it is until negotiations have concluded at summer's end. However, as in past years, we expect that our premiums will remain highly competitive and that out experience will track or remain below industry averages.

8. **Q.**. In light of recent premium increases, employees and retirees may be paying, on average, 20% more now than they were in 1996, and perhaps 30% more in the year 2000. In one year alone, 1998, some employees' premiums went up as much as 75%. Employees and annuitants have been complaining that these increases have consumed their annual pay increases and cost-of-living adjustments. Has OPM solicited recommendations from carriers for proposed benefit package designs that would significantly reduce the rate of growth in premiums or even lead to lower premiums? If not, would OPM consider such proposals?

A. OPM is always open to suggestions from carriers on benefit design changes, including those that would reduce the rate of growth of premiums and still maintain quality coverage for FEHB enrollees. Each year, in our annual call letter, OPM solicits carrier suggestions and considers them in its annual contract negotiations. Under OPM guidelines, benefit design changes must be cost neutral (this includes reductions in premium rates as a result of a benefit change). Premium rates for OPM-required initiatives that have a potential cost impact are reviewed by our staff, and where appropriate, are actuarially adjusted.

Any carrier benefit design proposal that is adopted, however, is plan-specific and is not likely to have an impact on the overall average cost of the FEHB or on the underlying factors of growth in plan premiums. Premium rate increases are driven primarily by three factors – increased utilization, medical inflation, and improved technology. Plan design changes are an ongoing process with our carriers and help to offset the impact of these three trend factors.

Mr. SCARBOROUGH. Thank you, Mr. Flynn. We appreciate it. In my opening statement I set out three questions that I said I thought were going to be important to be answered. I want to put them to you now and get your feedback. First of all, what problems in the FEHBP do the policy directives in the call letter that you sent out address?

Mr. FLYNN. Well, Mr. Chairman, I think the first thing I would do is just quickly go back through the topical headings in the call letter. I would be the last person to characterize those headings as problems in and of themselves.

For example, implementation of the DOD demonstration project is something that Congress passed last year and that we're in the process of implementing, I might add, on a cooperative basis with the health plans. We will be participating in that with the Department of Defense and other key stakeholders.

Y2K compliance, I think, will largely not be a problem, but it certainly is an issue that we must address.

Ms. Norton mentioned the President's Executive order directing Federal departments and agencies that administer health benefit programs to implement the President's patient's bill of rights. This is not a problem. It's an opportunity for us, I think, to do some good things.

In the areas of quality health care, family-centered health care, and enhanced customer service, I think what we're doing, Mr. Chairman, is encouraging health plans to build on strengths. So, you know, you can look at this in terms of the cup's half full or half empty. I would like to think it's more than half full and we want to make it better.

Mr. SCARBOROUGH. Do you see any of these directives causing the costs to go up further or causing the quality of health care for Federal employees to decline?

Mr. FLYNN. Mr. Chairman, when we lay out our negotiation objectives for the coming year, we look at, among other things, the impact on costs in this program. In the invitation letter, which you sent us, you asked us about our projected impact on increased costs in the program, and we've provided that.

I think that the total amount of increased costs that we expect in the program for 1999, based on the things that we are looking for, is somewhere in the neighborhood of about $20 million.

That covers things like 90-day transitional coverage as part of the patient's bill of rights initiative, for a cost of $3.8 million, and about $12 million for various types of preventive screening services, and a few other items like that. The two that I can see real quickly are about $15 million, or somewhere in that $15 to $20 million cost range.

Mr. SCARBOROUGH. OK. While we're talking about costs and increases, what about the question regarding how much you expected the premiums to go up?

I know we had asked you that question, and the answer was a bit ambiguous. While you can't look into the crystal ball, obviously, you had to consult with OMB while they were making their projections on how much they expected the costs to go up.

So could you give us something—and again I understand you can't look into the crystal ball until you finish negotiations this

summer, but could you give us and give people, especially that have a lot of Federal employees in their District, some sort of idea about how much you expect the premiums to go up?

Mr. FLYNN. Well, you're right, Mr. Chairman, we really won't know until it's over. I would just simply say a couple of things. First of all, you pointed out the differentials reflected in the President's budget. Those don't reflect premium increases per se. The numbers in the President's budget are on a fiscal-year basis. This program operates on a calendar-year basis.

The numbers in the President's budget reflect all income to the Federal Employees Health Benefits fund, not all of which reflects premium increases but some demographic shifts as well. So looking at those figures and using some standard assumptions about inflation and the economy, in general, produces those numbers; and they're not intended to be a reflection of what is expected to occur next year's premium.

I think the best thing that I can say about next year right now is that there will be an increase. I don't know how much it will be. But I'm confident that this program will look next year, just like it looked last year and in the years previous, like other health care programs, like what other private sector employer sponsors are experiencing, and we will do our best to manage with that.

Mr. SCARBOROUGH. I know you will. Obviously there are a lot of outside forces that you all can't control. Do you think it's safe to say, though, that it will most likely be a double-digit increase this year?

Mr. FLYNN. I would not go so far as to say double-digit increase, Mr. Chairman. Again, we won't know until it's over, but that is not where I would be at this point, but I cannot say with any definitive sense at this point.

Mr. SCARBOROUGH. OPM has, though, talked with OMB, have they not? What has OPM told OMB that they expect the increase to be?

Mr. FLYNN. Well, I think we, and OMB in the projections in the President's budget, assume among other things, that the general trend in medical inflation will be what it's been for the past several years; and for the past several years, it's been up there. Again it's an attempt to portray early on in the budget process what might occur.

Mr. SCARBOROUGH. Right.

Mr. FLYNN. But you really don't know until the rate proposals come in.

Mr. SCARBOROUGH. Right, and my red light is on. But was there a hard number that when OPM was talking to OMB, did you all say, well, it looks like it's going to be more than last year, it's going to be—I'm just trying to get—I'm certainly not trying to put you on the spot here. I'm just trying to get a ballpark, 2 percent is different from 12 percent, and you all have discussed this.

And, obviously, again, those of us that are up here have an awful lot of Federal employees that it should help if they can project what is going to happen 6 months from now.

Mr. FLYNN. Well, there is a specific number that we have agreed on. I don't know what that is exactly. But I would be glad to go back to the staff and provide it for the committee.

Mr. SCARBOROUGH. Great, I appreciate that. That would be helpful.

[The information referred to follows:]

The numbers in the President's Budget for the Federal Employees Health Benefits (FEHB) Program represent the total income to the Employees Health Benefits Fund in FY 1999 and FY 2000. Because these are income totals, the increases are due in part to changes in population assumptions. Further, the basis for these numbers is fiscal years rather that FEHB contract years that renew on a calendar year basis.

Our submission for the FY 2000 President's Budget anticipated an average increase in FEHB enrollee contributions of 9 percent for contract year 2000. Further, we estimated that total Government contributions will increase by 8.2 percent and that total permiums under the program will increase by 8.4 percent.

Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Let me just go back to something. The beneficiaries of all of this, of course, are the Federal employees, and you're trying to make sure that we have the best plan possible. And I was kind of struck by something that I read in Bobby Harnage's statement, from the American Federation of Government Employees—and he is going to testify in a few minutes—that the current structure of FEHBP gives Federal employees virtually no meaningful voice in setting premiums and benefits.

Has OPM solicited their recommendations? I mean, you know, like recommendations from employee unions for proposed benefit packages and designs that would possibly reduce the rate of growth of premiums? You know, I mean, have you had those kinds of discussions?

Mr. FLYNN. We certainly have had those discussions at an informal level, Mr. Cummings. I also read that statement and want you and everyone to know that to the degree that an organization such as AFGE feels somehow excluded from the process of being able to give us their opinions and views, that's something that I need to correct. And I would make a commitment to do that.

We do get a lot of input. We hear from individual employees, the National Association of Retired Federal Employees, Federal departments and agencies, unions, and health plans. There's a lot of input we get. We do customer satisfaction surveys. I've talked in my testimony about focus groups that we've conducted that have been facilitated by the Gallup organization.

The thoughts, the expressions of interests, the needs and desires expressed by the customers—the stakeholders in this program—are extremely important to us, and we need to look for ways in which we can get that input effectively.

Mr. CUMMINGS. Well, I just want to make sure—I agree with what you just said. It just seems to me that if I've got the beneficiaries who are paying the premiums saying we really want to sit down, we really want to work with you, because we're paying, we note the Federal Government is paying their piece, but we're paying, too, and our employees, you know, they want to get the best package for their dollar, and saying that maybe there's some things that we can tell you that will help.

I don't want us to be in a situation—and I'm sure all of us would agree with this up here—we don't want a situation where they're locked out, because they speak for a lot of people who are the beneficiaries of this. That statement really bothered me when I read it,

because I was just wondering if we are becoming such experts that we allow folks who could possibly help us out of the process.

And I'm glad to hear your commitment. And I hope that when I ask you that question again the next time I see you that we have—if correction is appropriate, and I take it that it is, just listening to what you just said, that that will take place.

Let me move on to something else. Mr. Allen a few moments ago talked about this whole thing of prescriptions, and I'm sure he will get into it even more. But I just had a press conference in my district—and I hadn't even talked to him about it yet—but about this whole thing of prescriptions and the elderly.

I was just shocked when I began to read the report that was done on my district with regard to the kinds of money that insurance companies—I mean the kind of discounts that are given to the preferred customers as opposed to my elderly people who don't have insurance.

It just got a phenomenal response in my district. People seemed like they came out of the woodwork. And I was just wondering, how do prescriptions play into this? I hope you don't mind me getting into this. How do prescriptions play into this whole premium situation? Can you help me with that?

Mr. FLYNN. Well, I will try, Mr. Cummings. This is a good deal from recollection, but prescription drugs in this program account for about $1 out of every $5 in the premium that's charged, about 20 percent. And as Mrs. Morella mentioned in her opening statement, in large measure because of the increasing role of prescription drugs in health care generally, but also I think in some respects it is attributable to the demographic characteristics of the group that participates in the Federal Employees Health Benefits Program. We have seen over the past several years these costs rising at annual rates of around 20 percent.

This is an area that, not just for us, but for health care administrators and people who have an interest generally, I think does need a lot of attention. Clearly, drugs play an important role in health, but clearly they are playing an increasingly larger role in terms of the costs of health. I don't have an answer to that. But it is a big issue for us as well.

Mr. CUMMINGS. The light is on, but, Mr. Chairman, just one other question.

Mr. SCARBOROUGH. Sure.

Mr. CUMMINGS. In your negotiations—and I'm not trying to get into anything that's secret or whatever—but, I mean, when you sit down and you talk about—if you're talking about 20 percent, I mean, and you sit down and you're trying to figure out, you know, just negotiating, I take it that there comes up discussions with regard to prescriptions, right?

Mr. FLYNN. Sure.

Mr. CUMMINGS. And I mean do you see any light at the end this escalating tunnel? I mean, in other words, do you see it getting at least stabilizing or getting any better?

Mr. FLYNN. Well, at last fall's hearing, Mr. Gammarino and a gentleman from Merck-Medco that runs a pharmacy benefit program both testified, and I would tend to agree, that there is nothing out there that one can point the finger at that says these

trends will stop. They offered some suggestions for controlling costs that had to do with copayments and deductibles and things like that.

And the only thing that I said that I thought we ought to begin to take a look at that I made some reference to in my opening statement this morning is that perhaps—because of the importance of this benefit and because just as you've mentioned, Mr. Cummings, the tremendously deep discounts that are given to volume purchasers—it is time for us to look at the possibility of carving out a national prescription drug benefit for the entire program, and perhaps look at partnering with other government agencies on the purchase of pharmaceuticals for Federal employees, retirees, and others who get benefits from Federal programs, as a way of perhaps controlling these costs.

But these are extraordinary times. Those are extraordinary increases, and those are the kinds of things that I think we need to consider.

Mr. CUMMINGS. Thank you.

Mr. SCARBOROUGH. Thank you, Mr. Cummings. Now, I see the voice of quiet moderation has entered the committee room. Mr. Mica from Florida.

Mr. MICA. Thank you, Mr. Chairman. I'm pleased to be with you again, and I'm shocked that Mr. Flynn has returned for another round of abuse. But welcome back, Ed.

Mr. FLYNN. Thank you, sir.

Mr. MICA. Mr. Flynn, how many folks do we have that are policyholders——

Mr. SCARBOROUGH. Mr. Mica, you are soft spoken. I'm having trouble hearing you. If you can get a little closer.

Mr. MICA. How many folks do we have that are policyholders in FEHBP?

Mr. FLYNN. I believe the number is about 4.1 million.

Mr. MICA. 4.1 million?

Mr. FLYNN. I believe that's correct. It's in that range.

Mr. MICA. And how many of the 4.1 million would be affected by the patient's bill of rights?

Mr. FLYNN. All of them, sir.

Mr. MICA. All of them. So your calculation of $10 per year for each policyholder would be $41 million?

Mr. FLYNN. Yes. It actually works out, Mr. Mica, to a little bit less than $10 a year. I think the precise calculation is about $8.61. And I think actually the range is about $35 million.

Mr. MICA. Well, President Clinton attended an event in Philadelphia on April 9th to promote his patient's bill of rights and director LaChance, with whom you may be acquainted, was also at the event. The President said that the patient's bill of rights was implemented in the FEHBP for less than a $1 a month per enrollee. Is that pretty accurate?

Mr. FLYNN. Yes, sir. I believe he said less than $1 a month and less than $10 a year.

Mr. MICA. He made it sound like less. He said less than a $1 a month, and you said $10. But you said the total is between $35 and $40 million probably?

Mr. FLYNN. I think actually between $30 and $35 million, Mr. Mica.

Mr. MICA. When we held the original hearings on the President's bill of rights proposal, it's my understanding that just about everyone testified that there was no medical benefit, most of the patient's bill of rights dealt with regulatory items or mandates.

Mr. FLYNN. Well, I don't think I would characterize my testimony in that way, Mr. Mica.

Mr. MICA. Well, what specific medical benefit is there? Is there additional mental health coverage or additional—specific medical benefit?

Mr. FLYNN. Well, yes, Mr. Mica, I believe so. In fact, if I might just take a moment. One of the things that you were particularly concerned about at that hearing was the estimate, if you will recall, of about $17 million for information disclosure, which I think has potential to have a direct impact on people's health. And let me take one example——

Mr. MICA. Again, direct medical benefit, can you point to one single direct medical benefit?

Mr. FLYNN. Yes, sir, I believe I can. I was just trying to do that very quickly. I think that the evidence is ample throughout the United States that one of the ways in which people stay healthy is by following the instructions of their providers, by following the instructions that are contained on the prescription medicines that they're supposed to take, and so on and so forth. And there is a great problem with people's understanding of that.

Mr. MICA. So it costs us $35 to $40 million——

Mr. FLYNN. No, sir.

Mr. MICA [continuing]. For that benefit?

Mr. FLYNN. No, sir, not at all.

Mr. MICA. Let me just ask you, since I don't have a lot of time. We had testimony before about the amount of increase in premiums, the average increase in premiums. What was the percentage?

Mr. FLYNN. The average increase in the total premium last year was just over 10 percent and about 7.4 percent, if I recall correctly, for individuals.

Mr. MICA. So a 10 percent increase in premiums. Didn't we also have a reduction in the number of people participating as far as plans?

Mr. FLYNN. We had a reduction in the number of plans participating, Mr. Mica, of about 60 to 65 or thereabouts, yes, sir.

Mr. MICA. Dropped out.

Mr. FLYNN. Mostly small health maintenance organizations comprising less than 2 percent of the total enrolled population.

Mr. MICA. Patient's bill of rights with no tangible direct medical benefits, an increase of 10 percent, and then a reduction in choices of plans available is sort of my take on this.

Mr. FLYNN. Well, I think it would be a mistake to draw that conclusion, Mr. Mica. I think that we've demonstrated that we're talking about less than $10 per year per person with a total premium of $4,400, and that seems to us to be a prudent investment in some of these protections.

Mr. MICA. As the former Chair of the subcommittee, I have had a chance in the last month and months since I left that position to talk with hundreds of Federal employees. And most of them are concerned about less money in their paycheck and higher premiums and concerned again about a system that was pretty cost effective and accessible to them, now getting expensive and inaccessible.

And then I talked to the other folks, the providers, and they're boxed in by more regulations, more mandates. In fact, one of my other concerns is the inability of some of the vendors who are providing these services to know exactly what they're to provide or be able to provide it and still stay competitive in our system that was modeled to provide competition.

I guess my time is about up. But what do you think about my responses to those folks that are looking for lower premiums, rather than higher premiums, and vendors who are providing services who are looking at fewer regulations and mandates and paperwork as opposed to more, which we're imposing?

Mr. FLYNN. Mr. Mica, the way I would respond to that is to say, first of all, I would want to have an opportunity to listen to and consult with anybody who expresses those kinds of concerns. If there are good ideas to make this program run better, I certainly want to make sure that we take a look at them.

I would also say that the overwhelming evidence that we get from participants in this program and from the health plans with whom we participate is exactly the opposite of that, and that most people do, in fact, believe they have a good health program.

They are concerned about the costs, but they get good value for the dollar. And I think we have a demonstrated track record of partnership with the health plans that participate in this program.

Mr. MICA. Mr. Chairman.

Mr. SCARBOROUGH. Thank you, Mr. Mica. Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman. I want to make a few comments following up on Mr. Mica's comments and then turn to some questions for you, Mr. Flynn.

First of all, I guess I would point out that, as you have testified, the prescription drug costs in this program are going up by 17 percent last year.

Mr. FLYNN. In that range, yes, sir.

Mr. ALLEN. In that range, 17 to 20 percent. In fact, for prescription drugs, the purchases, total purchases for prescription drugs across the country have been going up 15, 16, 17 percent, now year after year after year. And if we're talking about how to save money on programs and we're worried about $8.61 per year to put in patient protections, we ought to turn our attention to the pharmaceutical industry, which is by far the most profitable industry in this country.

There are lots of ways of measuring profits. But in terms of return on revenues, the pharmaceuticals earned 18.5 percent, No. 1 in the country; return on assets, 16.6 percent, No. 1 in the country; return on equity, 39.4 percent, No. 1 in the country. If we're looking to control costs in any health care plan and we do not pay attention to the prescription drug costs, we are making a fundamental mistake.

Let me turn more narrowly now to a specific issue. The data that we have for the Blue Cross and Blue Shield program is that I think you said 20 percent of the program's total expenditures were for prescription drugs. I don't know if that was the Federal Employees Health Benefits Plan overall or the Blue Cross and Blue Shield portion.

Mr. FLYNN. Overall. But I would suspect that the Blue Cross and Blue Shield is not much different from that.

Mr. ALLEN. OK. Assuming that it's 20 percent or somewhat higher, one of my concerns is how that benefit is managed and, in particular, you have a 20 percent copay for members who buy their drugs at pharmacies, but no copay if they buy it through mail order.

One of my concerns is that at the local pharmacy today, people get some advice. They get some help; the pharmacists know their drugs and can help people manage them. I question whether you get the same kind of hands-on management from mail order.

My question is really if you can talk to us about how that prescription drug benefit is managed and also how—whether or not you think that the utilization, the overall use of prescription drugs might be driven down if you equalized sort of the playing field between mail order and retail pharmacies.

Mr. FLYNN. Mr. Allen, first of all, you've brought up what is a very important issue and something that has been an important issue between us and the Blue Cross and Blue Shield Federal Employee Program in the course of our negotiations with them.

Let me try and answer the larger issue about copayments between the local pharmacy and mail orders first and then talk a little bit about the situation with respect to Blue Cross and Blue Shield.

With the 285 plans that participate in this program, we really rely on them for expertise and benefit design in the establishment of copayments and copayment differentials; and we look to them to propose how to modify those designs from one year to the next.

As long as they are reasonable and seem to be within the general mainstream of practice, we negotiate and generally accept different kinds of benefit designs for prescription drug programs from one health plan to another.

With respect to the Blue Cross and Blue Shield prescription drug program, it is no secret, because it has been talked about in testimony before this subcommittee on a couple of occasions, that the Federal employee program does believe that the imposition of a copayment on Medicare-eligible retirees for their mail order drugs would be an important way to rationalize their benefit design and to insert some utilization controls at that particular distribution point.

I note from reading their prepared testimony that this remains an issue with them. I'm not surprised that it is. And I'm sure that we will have long and fruitful discussions over that over the course of our negotiations this summer. But I'm not really in a position to talk about the outcome of that at this point.

Mr. ALLEN. One followup, is there any concern that the primary mail order contractor for the program Merck-Medco is owned by a

manufacturer and might have some conflict of interest in terms of encouraging utilization of its own products?

Mr. FLYNN. No, Mr. Allen. Again, just to clarify, what we're talking about here is the Blue Cross and Blue Shield drug program, not the drug program for the Federal Employees Health Benefits Program in general. When Merck-Medco was established, that was a concern, the fact of its affiliation with the pharmaceutical manufacturer, Merck, and a number of fire walls were put into place to assure that there wasn't some sort of incorrect or improper influence applied.

I think Blue Cross and Blue Shield can speak more directly to that. But I know it was a matter that was looked at by the Federal Trade Commission. And, of course, Merck-Medco as the mail order pharmacy benefit manager for Blue Cross and Blue Shield covers lines of business that are far more extensive than the Federal employee program.

All of our indications, I might add, from the customers' satisfaction surveys we've done, show people are very satisfied with the service they get from that particular contractor.

Mr. ALLEN. Thank you. Thank you, Mr. Chairman.

Mr. SCARBOROUGH. Thank you, Mr. Allen. Ms. Norton.

Ms. NORTON. Thank you very much, Mr. Chairman.

May I note that in the rear are students from Bruce Monroe Elementary School who are part of a program that I started called D.C. Students in the Capitol. Its purpose is to make sure that every youngster in the District has to come to the Capitol at least once, meet their own Congresswoman, see what the Capitol is like, especially since so much of our business unfortunately gets transacted here.

These students happen by chance to go to the same elementary school I went to, and I have said to them that I was particularly pleased to see Bruce Monroe here, because when I went to Bruce Monroe there was no representative to come to see, there was no Mayor and there was no city council. So to see them here is for me especially poignant.

Like Mr. Allen, I am very concerned about the pharmaceutical costs and recognize that the burden is on the plans to be competitive here and to hold down costs. I wonder if you are aware of changes from year to year in the number of Federal retirees who may have changed their vendors for prescriptions from local pharmacies to mail order purchasing.

Mr. FLYNN. I don't have any of those numbers at my fingertips, Ms. Norton. We probably have some data that we could extend or extrapolate to the overall program to demonstrate the movement into mail order, particularly for maintenance drug therapy. We could provide this to you at a later point, if that would be of interest.

Ms. NORTON. Well, I mean it's of interest. One of the reasons—I ask about retirees. They may have been slow to change vendors because they are used to going into the local pharmacy.

Well, of course, without some substantial education, you may not know that the best delivery may be in the mail, where the same delivery can occur and then the costs are substantially less often for those kinds of transactions, except that if that's not the way

you've done it for most of your life, most of your adult life, it's not most likely to occur.

This kind of education—is this kind of education a part of what you do at OPM? How do you change people's habits? If it is your job to hold down costs, isn't part of that job to help people recognize that they can get the same benefit, for example delivery, that you might have gotten from the local pharmacy, at a greatly reduced cost?

Mr. FLYNN. Part of our job, Ms. Norton, is to educate and inform. We do a great deal of that through the materials that we produce. The health plans that participate in the program do so as well.

I would just point to another area of this program as an indication of the degree to which this particular retired population is willing to change. The Office of Personnel Management, among all agencies that pay retirement benefits, has the highest rate of EFT participation, about 90 percent.

Ms. NORTON. Say that again.

Mr. FLYNN. We have the highest rate of electronic funds transfer participation, among all benefit-paying agencies, at about 90 percent for our retirees. When we do surveys of the National Association of Retired Federal Employees and others, we find that computer utilization, Internet access, things like that, are all way above the national averages.

So I think this sort of tangential evidence is good, but I do think we have an educational challenge in front of us. There will always be ways we can do it better, but we have responsibilities. We share them with the health plans, and we want to make sure that people understand how they can get that.

Ms. NORTON. Maybe retirees have a great incentive to watch this sort of thing. It may be—the problem may be with employees. I mean, I suppose at—the root of my question is what kind of education are you doing on this kind of change with employees and retirees, because unless these habits are changed by the consumer, then you're going to have problems holding down costs because you haven't educated people about holding down costs.

I ask about this cost—I've had experience myself in the difference between ordering something from a vendor, that's covered by a plan, and going to the drug store and there is a very substantial difference here.

Mr. FLYNN. Yes, there is.

Ms. NORTON. When one gets information that says you can change your health care plan, you almost want to put it down, unless there's something that very easily indicates what the differences would be and points them out to you. Is that kind of information available to employees?

Mr. FLYNN. Yes, it is, Ms. Norton. And we make extensive efforts to provide it. In fact, I will just mention one very quickly. We've been involved, in partnership with the health plans, in a major effort to make sure that our informational and educational materials are written in plain language so that we broaden the base of people who understand and who can act on the basis of good understanding of what's in their best interests. I think that's been an important effort. And I look forward to some of the results of that.

Ms. NORTON. If I might ask a question about the costs of the patient's bill of rights. One of the costs was direct access to OB/GYN, as I recall, it was $2.9 million.

I was interested that that cost was only a million dollars less than the costs of transition costs, the transition costs of keeping people on plans. I really didn't understand that figure, particularly since most younger women, and I think even middle aged and older women, use OB/GYN—or one or the other far more than anything else.

Aren't there two transactions? I mean, why isn't that saving money, if, in fact, the great majority of women use an OB and/or GYN?

If I go first to my internist, then he says why don't you go see my gynecologist, then, of course, there are two charges. I don't understand why there is this $2.9 million for women to go straight to OB/GYN, and I would like to see some figures that would indicate why there would be an increased charge—an increased cost, I'm sorry.

Mr. FLYNN. Sure. And I will be happy to go back with our actuaries and provide for you for the record if that's acceptable.

Ms. NORTON. What percentage of women use a physician mostly for OB and/or GYN?

Mr. FLYNN. I don't personally know that today. Certainly we can provide that information for the record.

Ms. NORTON. You have no idea why this $2.9 million is listed as a cost of going directly to OB/GYN?

Mr. FLYNN. It is——

Ms. NORTON. Or what accounts for the costs?

Mr. FLYNN. It is primarily the change in the benefit pattern within those few plans that didn't already provide direct access to OB/GYN.

Ms. NORTON. I'm sorry. Changing the benefit pattern—if I can just get this clarified. What does that mean? I can't answer what you mean.

Mr. FLYNN. It essentially allows women to have direct access for routine screenings and other preventive care without having to go through a primary care physician. As to the basis for that $2.9 million cost estimate, I don't have all the details in front of me, but, as I say, I would be happy to provide it. But it's a very, very small number in the final analysis, in any event.

Ms. NORTON. Small number. I don't know why it's $2.9 million. You see the hypothesis, what you have indicated is counterintuitive.

Mr. FLYNN. It is counterintuitive.

Ms. NORTON. My hypothesis would be instead of two transactions there ought to now be one, since I believe most women use an OB/GYN. And so I would like an explanation for that figure, and I would like it to be provided both to the committee and to me.

Mr. FLYNN. Mrs. Norton, absolutely I understand it is counterintuitive, and that's why I would like to provide a more complete answer if I could.

[The information referred to follows:]

In our responses to questions that the Subcommittee included in the hearing invitation, we assigned monetary values to each recommendation from the President's Patient's Bill of Rights that will be available to all Federal Employees Health Benefits (FEHB) Program enrollees by the year 2000. The $2.9 million figure for direct access to gynecologists for routine and preventative women's health care reflected the following rationale:

In Health Maintenance Organizations (HMOs), primary care physicians are generally paid on a capitated basis. That is, they receive a specified amount from the HMO for each patient regardless of the level services they provide. The primary care physicians may never see some patients in a given year and seeing a patient for a referral does not generate extra costs to the HMO. Specialists, on the other hand, are generally paid on a service-performed basis. There are many examinations and procedures that can be provided by either a primary care physician or a gynecologist. With direct access, specialists will perform some of these services on a fee basis rather than the plan providing services, at no additional cost, through a capitated primary care physician, and this generates additional costs for the plan.

Although we estimated the total value of Patient's Bill of Rights protections for a population such as the FEHB Program at $33.5 million, the actual costs incurred are much less because most FEHB plans already were in substantial compliance. Indeed, only a handful of our carriers sought an explicit rating adjustment and the total adjustment made for 1999 was less than $250,000.

Mr. SCARBOROUGH. Thank you for this line of questioning and also for this great program. What is it called, Classroom in the Capitol?

Ms. NORTON. D.C. Students in the Capitol.

Mr. SCARBOROUGH. Why don't you all raise your hands? What grade are you in, sixth grade? OK. Well, thanks for visiting us today and go home and tell your families and all of your friends that are of voting age that Mrs. Norton continues to fight for you in committees and on the House floor, and that she's also a great champion for you, a great example of what you can do. One of you ought to come and take her place after she retires.

Mr. MICA. Soon.

Mr. SCARBOROUGH. Not soon, Mr. Mica, not soon. Just ignore Mr. Mica, he's a mean-spirited Republican. You can go back and tell your parents that, too. So thank you for coming. We appreciate it.

Speaking of mean-spirited Republicans, Mr. Mica has one very quick followup question, and if anybody over here in the gentle section wants to ask a quick followup, we will be fair. Mr. Mica.

Mr. MICA. Well, again, you've described this as only $10 a year more, the President a dollar a month, and actually we're at a $35 to $40 million a year increase. And you said there was a 10 percent increase last year on average. I believe those are the correct statistics.

What contributed the most to the increase in the last year? Was that prescription drug costs?

Mr. FLYNN. Yes, sir.

Mr. MICA. And that leads me to my question: What did the patient's bill of rights do to help in that area? Anything to bring down the costs or deal with the problem of the biggest escalating factor?

Mr. FLYNN. Well, Mr. Mica, the patient's bill of rights is not intended to address any particular aspect of health care per se. It's designed to provide access to information, safeguards to assure——

Mr. MICA. Did it do anything to help in that area that we've experienced the greatest amount of costs?

Mr. FLYNN. The only way that I could really answer that, Mr. Mica, is to say that the patient's bill of rights wasn't per se intended to reduce costs. It was intended to better balance the rights of individuals who participate in managed care health insurance programs.

Mr. MICA. And one area where it could have reduced costs, for example, in the direct access to OB/GYN services, which was pointed out here, we haven't seen that happen?

Mr. FLYNN. Only because of my own inadequacies, Mr. Mica. I would be happy to provide additional information for the record.

Mr. MICA. We look forward to your additional information.

Thank you, Mr. Chairman.

Mr. SCARBOROUGH. And, Mr. Mica, let his humility be an example to you talking about inadequacies.

Mr. Allen, you have a followup, also.

Mr. ALLEN. I just thought in light—I guess I should say, Mr. Mica, if you want to sign on to a bill that would reduce prescription drug costs for the elderly, I have a bill for you. But we can talk about that afterwards.

I just thought it would be useful to put the numbers on the table we were talking about, on the one hand, about $35 million being the overall global costs for the patient's bill of rights.

Could you give me two numbers: one, give me the dollar number that reflects the 10 percent premium increase; and then the 100 percent, the total premiums paid by Federal employees under this Federal health care plan.

Mr. FLYNN. Well, in round numbers, 10 percent——

Mr. ALLEN. All I'm asking is round numbers.

Mr. FLYNN. Ten percent increase in round numbers is going to be about $1.7 billion. And the total premium income to the program—and I don't have my calculator with me—but if you figure an average premium, Mr. Allen, of about $4,400 per year and 4.1 million policyholders in the program, you should get pretty close to the total costs.

The thing that I would just emphasize is that that total is then on average split 28 percent being paid by the individual employee or retiree and the balance of 72 percent being paid as the government contribution toward the cost of that care.

Mr. ALLEN. I thank you. I just wanted to have the numbers in context.

Thank you, Mr. Chairman.

Mr. SCARBOROUGH. Thank you, Mr. Allen.

We certainly appreciate your testimony here today. And I know you're a very busy man, and I apologize for keeping you waiting 20 minutes at the beginning. But thanks again. We look forward to seeing you soon.

Let's call up our next panel. We have Steven Gammarino who is senior vice president of the Federal Employee Program, Blue Cross and Blue Shield Association. We have Dr. Joseph Braun, chief medical officer at George Washington University Health Plan, and we have Bobby Harnage, Senior, president of the American Federation of Government Employees.

All right, gentlemen, if you could raise your right hands.

Dr. BRAUN. I happen to be a Quaker. Could I affirm to the oath instead of swearing to it, please?

[Witnesses sworn or affirmed.]

Mr. SCARBOROUGH. Please have a seat.

And let's start with Mr. Gammarino, senior vice president, Federal Employee Program, Blue Cross and Blue Shield Association.

STATEMENTS OF STEPHEN W. GAMMARINO, SENIOR VICE PRESIDENT, FEDERAL EMPLOYEE PROGRAM, BLUE CROSS AND BLUE SHIELD ASSOCIATION; DR. JOSEPH BRAUN, CHIEF MEDICAL OFFICER, GEORGE WASHINGTON UNIVERSITY HEALTH PLAN; AND BOBBY L. HARNAGE, SR., PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Mr. GAMMARINO. Good morning, Mr. Chairman and members of the subcommittee. I thank you for the opportunity to appear before this body today about the changes for the year 2000. I'm also pleased to note that this is my first appearance before the subcommittee since you became chairman, Mr. Scarborough. Blue

Cross and Blue Shield looks forward to continuing a productive relationship with the subcommittee.

My testimony today will highlight several trends affecting the program currently that we believe are adversely impacting the well-being of the program.

These trends are: the increasing administrative burdens on participating carriers, reduced carrier flexibility, movement away from a level playing field, and the standardization of health plan administration.

Before I go further, Mr. Chairman, since I will be summarizing my testimony, I would like my full written testimony to be put into the record.

Mr. SCARBOROUGH. Without objection, so ordered.

Mr. GAMMARINO. These trends will be reflected in my comments today in the following areas: the impact on costs and quality of the policies set forth in this year's call letter and other matters of concern to the Blue Cross and Blue Shield Association.

Your invitation requested our views on how the provisions of OPM's call letter for the year 2000 are likely to impact the costs and quality of health care coverage. Implementation of the patient's bill of rights is one case in point. For example, we have a requirement that patients have a right to obtain and amend his or her medical records.

This will potentially require us to change our provider agreements. Such contract changes are inappropriate, we feel, for our plan. With a network of more than 400,000 providers and provider contracts developed, in most cases, for the Blue Cross and Blue Shield plans' commercial business, directing our local plans to recontract for these issues would come at a tremendous cost and, we think, add very little value to the program.

We simply have no reason to be involved in the relationship between the physician and the patient with regard to medical records. We're also concerned that should we attempt to recontract for this issue it is possible that some providers may simply refuse, thus reducing in size the broad networks which our enrollees expect and rely on today.

With proper consultation between the agency and carriers and reasonable flexibility, as was shown last year, it is possible that the substance of the patient's bill of rights could be implemented without major adverse impact on the program.

However, I should note that the set of requirements OPM is requiring are quite distinct from any of the various patient right acts currently being considered before Congress.

Indeed, despite the assertion by some that the FEHBP experience demonstrates that the pending patient's bill of rights would not be costly, the requirements of the bill being implemented in the FEHBP last year and this year are significantly less onerous for health plans than some of those being discussed on Capitol Hill today.

One final initiative mentioned in the call letter concerns the Department of Defense Demonstration Project for Participation by Military Retirees. Now, this area is also a cause for concern. While we share the agency's interests in setting premiums that are at an attractive level for eligibles, we are concerned about their intent to

ensure participation while mitigating carrier risk. We have, in discussions with OPM, told them we believe their intended course of action with regard to financing this project is contrary to law and incompatible with the very structure of the program.

Please let me explain. One percent of the premium in the plan in the program is set aside in the administrative reserve, the purpose of which is to cover OPM expenses in administering the program, OPM uses only a small fraction of the available amount and the unused portion is distributed to carriers based on their market share in accordance with the directions in the law.

We understand that the agency proposes to utilize the unused portion of the reserve to pay off any deficits carriers may incur because of the demonstration project without regard to the statutory instructions.

We find absolutely no basis in current law for this action. The legislation that authorized the demonstration project gave OPM access to the reserve to defray any additional costs it may incur, but it said nothing about carrier costs and did not in any way alter the distribution scheme set forth in the basic law.

Now why is this important? It is important because OPM's proposed action is incompatible with the concept of an insured competitive program, which is what the FEHBP is in law and in fact.

OPM would, in effect, be redistributing the premium income among the carriers, taking money that was derived from one carrier's premium and giving it to another. In a self-insured program, this would not be a problem; but in a competitive insured program, it undermines the integrity of the rate-setting process and erodes the basis for carrier liability.

Now, while the call letter draws attention to specific program-wide initiatives for the coming year, there are, of course, other issues affecting the FEHBP in general that are not addressed in the call letter. One area of great concern to us is the administration's continuing efforts to impose the cost accounting standards on this program. These standards, which are developed primarily for contractors doing business for the Department of Defense, are overseen by the Cost Accounting Standards Board.

As you know, upon the requests of this subcommittee and the Committee on the Government Reform, Congress included a provision last year exempting carrier contracts in this program. The administration, specifically OMB, opposed this provision at the time, even though OPM was on record as recognizing the inherent difficulties in attempting to fit these standards in this program.

We note that the President's fiscal year 2000 budget proposes to delete this exemption. The Blue Cross and Blue Shield Association actively sought this exemption last year and, with your help, obtained that exemption. Simply put, for reasons stated by many—before many subcommittees before, Blue Cross and Blue Shield Association, as the agent for the plans, cannot sign a contract with OPM that contains a cost accounting standard clause, or that otherwise applies cost accounting standards coverage.

Given the administration's reluctance to recognize the inappropriateness of applying the cost accounting standards to our program, as evidenced by the proposal to delete the exemption, we're also convinced that congressional intervention is required. Once

again, we ask for your assistance in retaining this statutory exemption.

The second area of significant concern is the lack of sufficient flexibility to adapt our benefit structure to the trends affecting us today. The cost trends, for example, in prescription drugs continue to outpace by far all other benefit trends. The demand for new, expensive drug therapies continues to increase, fueled by direct-to-consumer advertising.

Other factors, such as the aging of enrollee population, also contribute to the rising costs, as I testified last year. And in the Service Benefit Plan, we continue to experience wastage and high utilization that is encouraged by the availability of "free drugs" for some of our enrollees. We have sought to control our costs by introducing cost sharing, but in the past 2 years we have simply been told no.

In summary, the fundamental strength of the FEHBP has been derived from a number of important features: the ability of enrollees to select from a number of competing health plans that best meet their needs; the ability of carriers to compete on a level playing field, and to bring needed and attractive products to the marketplace; and, finally, the ability of the program administrators to make intelligent choices, consistent with the law and regulation.

Thank you, Mr. Chairman, once again, on behalf of Blue Cross and Blue Shield. I appreciate the opportunity to come before you, and I would be pleased to answer any questions at this time.

Mr. SCARBOROUGH. Thank you, Mr. Gammarino.

[The prepared statement of Mr. Gammarino follows:]

TESTIMONY OF

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Before the

Subcommittee on Civil Service
Committee on Government Reform
United States House of Representatives

On

FEHBP: OPM's Policy Guidance for 2000

Presented by:

Stephen W. Gammarino
Senior Vice President
Federal Employee Program
And Health Care Management Systems

May 13, 1999

Mr. Chairman and Members of the Subcommittee:

Good morning. I am Stephen W. Gammarino, Senior Vice President, Federal Employee Program and Health Care Management Systems, at the Blue Cross and Blue Shield Association. On behalf of the Association, I thank you for the opportunity to appear before you today to discuss the guidance we have received from the Office of Personnel Management (OPM) for 2000, as well as other issues of importance to the FEHBP. I am also pleased to note that this is my first appearance before the subcommittee since you became Chairman, Mr. Scarborough. Blue Cross and Blue Shield looks forward to continuing a productive relationship with the subcommittee.

As you know, Blue Cross and Blue Shield Plans jointly underwrite and deliver the Government-wide Service Benefit Plan. This plan has been in the federal program since its inception in 1960 and is the largest plan in the program. The Service Benefit Plan currently covers almost two million contracts and more than 3.8 million lives.

My testimony today highlights several trends affecting the FEHBP currently that we believe are adversely impacting the well-being of the program overall. These trends are:

- The increasing administrative burden on participating carriers as additional regulations and further mandates are imposed;
- Reduced carrier flexibility in delivery of health care coverage as a result of OPM initiatives;
- Movement away from a "level playing field" among carriers with regard to flexibility in administration and benefits; and
- The standardization of health plan administration and benefits, thus reducing enrollee choice in the FEHBP.

These trends will be reflected in my comments today on the following areas:

- The impact on cost and quality of the policies set forth in this year's call letter; and
- Other matters of concern to the Blue Cross and Blue Shield Association regarding the FEHBP.

Call Letter Guidance

Your invitation requested our views on how the provisions of OPM's call letter for 2000 are likely to impact the cost and quality of health care coverage in the FEHBP. While we are generally opposed to mandates and believe they have an adverse effect on the cost and affordability of coverage, the level of impact can vary significantly with the degree of flexibility that carriers are allowed in implementation. Although negotiations have not yet begun, we are hopeful that the agency will allow the same flexibility concerning the various initiatives set forth in this call letter as was allowed last year.

Implementation of the Patients' Bill of Rights is a case in point. As the call letter notes, much of what was required as a result of the President's Executive Memorandum was put in place for 1999. Two of the changes proposed for 2000, however, could pose significant problems: the provision of transitional care for members forced to change providers or health plans and the patient's right to obtain and amend his or her medical records. Both are put forth as potentially requiring provider contract changes. Such contract changes are inappropriate for the Service Benefit Plan. With a network of more than 400,000 providers and provider contracts developed in most cases for Blue Cross and Blue Shield Plans' commercial business, directing our local Plans to recontract for these issues would come at a tremendous cost, if it were even possible. And such cost would bring very little value to the program, especially in the case of patient access to medical records; the carrier simply has no reason to be involved in the

relationship between the physician and the patient with regard to medical records. We are also concerned that, should we attempt to recontract for these issues, it is possible that some providers may simply refuse, thus reducing in size the broad networks which our enrollees expect and on which they rely. In this instance, it is essential that OPM allow for compliance strategies other than recontracting.

In the area of network and provider information disclosure (e.g., compensation methods, years in practice, languages spoken, etc.), the message put forth in the call letter is that, for the provider-specific, detailed information required by the Patients' Bill of Rights, carriers may refer members to providers. This is the appropriate and reasonable approach. Although such detailed information might prove helpful in some instances to members seeking out providers with particular characteristics, such information would be extremely difficult and costly for carriers to collect and then maintain.

With proper consultation between the agency and carriers and reasonable flexibility, then, it is possible that the substance of the Patients' Bill of Rights could be implemented without major adverse impact on the program. However, I should note that the set of requirements I have been discussing is quite distinct from any of the various patients' rights acts currently being considered here in Congress. Indeed, despite the assertion by some that the FEHBP experience demonstrates that the pending Patients' Bill of Rights measures would not be costly, the requirements of the "bill" being implemented in the FEHBP in 1999 and 2000 are significantly less onerous for health plans than some of those now being discussed. For instance, in the past two years, there has at no point been discussion of health plan liability in the FEHBP that would allow enrollees to sue carriers. Additionally, although external review was an element of the bill being implemented, OPM (employer) review was and should be deemed adequate to meet this requirement; current proposals require external review independent of

the health plan or sponsor. If such requirements were to be imposed in the FEHBP, without question, the costs would be significant.

We also have concerns about the potential impact of initiatives discussed in the call letter under the rubric of "Quality Healthcare." These initiatives involving quality indicators and outcomes measurements appear not to take into account the differences among types of health plans in the FEHBP. A strong example of this is the collection of HEDIS data. We support the agency's initiative to make as much information available as possible for federal employees and annuitants to compare health plans, and by adding HEDIS data to this effort, an attempt to provide comparisons of quality is being made. Yet such a comparison can prove misleading when made between a PPO like the Service Benefit Plan and an HMO. With regard to the data available, PPOs primarily have only claims data, which is insufficient for HEDIS measures. HMOs, by contrast, have in many instances contractual provisions with providers for the collection of detailed information, including outcomes data, as well as medical records review. Perhaps more importantly, the HMOs have the administrative and contractual mechanisms in place to effect a change in provider behavior should that data reveal a quality-of-care issue. With such fundamental differences, we do not believe an apples-to-apples comparison can be made. Absent a measurement scheme that can deal with these differences, collection and dissemination of comparative "quality" data is likely to be more misleading than informative.

Were we to be required to report HEDIS-type quality measures, in order to do so, we would have to:

1. Incorporate mechanisms, such as gatekeepers, for coordinating and managing care;
2. Introduce provider capitation and incentive payments in our physician contracts;
3. Eliminate open access to non-network providers;

4. Recontract with providers and enter into a much more information-intensive relationship, including ongoing access to patient medical records; and
5. Reduce significantly the number of physician and other health care providers available within the network.

In essence, we would become an HMO, abandoning those features for which enrollees select the Service Benefit Plan in the first place: broad networks, easy access to providers and limited involvement in the physician-patient relationship.

Department of Defense Demonstration Project

One final initiative mentioned in the call letter, the Department of Defense Demonstration Project for participation in the FEHBP by military retirees, is cause for considerable concern. We share with the agency an interest in setting premiums at an attractive level for eligibles to ensure adequate participation, while mitigating carrier exposure to additional risk. However, based on an oral exchange with OPM officials, we believe their intended course of action with regard to financing the project is contrary to law and incompatible with the very structure of the FEHBP. Let me explain.

By law, one percent of the premium of each plan in the FEHBP is set aside in an Administrative Reserve, the purpose of which is to cover OPM's expenses in administering the program. OPM uses only a small fraction of the available amount and the unused portion is distributed to carriers based on their market share, in accordance with explicit directions in the law. We understand that OPM proposes to utilize the unused portion of the reserve to pay off any deficits carriers may incur because of the demonstration project without regard to the statutory instructions for distributing the funds. We can find absolutely no basis for such action in law. The legislation that authorized the demonstration project gave OPM access to the reserve to defray any additional costs it may incur

because of the project, but it said nothing about carrier costs and did not in any way alter the distribution scheme set forth in the basic law.

Why is this issue important? It is important because OPM's proposed action is incompatible with the concept of an insured, competitive program, which is what the FEHBP is in law and in fact. OPM would in effect be re-distributing premium income among the carriers, taking money that was derived from one carrier's premium and giving it to another. In a self-insured program, this would not be a problem. In a competitive, insured program, it undermines the integrity of the rate-setting process and erodes the basis for carrier liability.

We believe that, rather than by way of OPM's problematic proposal, the objectives of affordable premiums and limited carrier risk are attainable within the letter and spirit of the law and the financial structure of the program. Congress clearly intended that the DOD enrollees be kept separate for rating purposes so that the group would be as self-sustaining as possible and its experience could be tracked and compared with that of the larger group of civilian enrollees. But Congress also intended that they be part of the overall program and not a separate insured group. We believe the objectives of the demonstration are best served, consistent with the provisions of the law, by establishing a separate rating category for the DOD eligibles (similar to the separate categories for High and Standard Options or self only and family coverage) while including them with the larger group for carrier liability and financing purposes. We have communicated our position twice to OPM in writing, but have as yet received no reply.

Let me assure you that the Blue Cross and Blue Shield Association is committed to ensuring the success of the demonstration project for military retirees. We anxiously await guidance from OPM regarding critical operational issues related to the project so that we may begin implementation. However, unless we soon receive such guidance as well as satisfactory resolution of the financial issue, our

ability to handle this population during Open Season and in 2000 will be jeopardized.

Mental Health Coverage

One issue that was unexpectedly absent from the call letter was mental health coverage. It has been our understanding for some time that OPM would soon be informing health plans of its intent to mandate mental health parity in the FEHBP in 2001; we have recently been told informally by the agency to expect formal notification in June. It was also indicated that the mandate would include an expectation of providing coverage in a managed setting.

While we do not know any other details of OPM's proposal, I can already express to you our reservations regarding the administrative challenges the Service Benefit Plan, in particular, will face in implementing such a mandate. Whereas many HMOs participating in the FEHBP use managed behavioral health care companies already to provide networks and administer mental health and substance abuse benefits, the Service Benefit Plan and most other fee-for-service carriers do not have a "gatekeeper" in place for these benefits, and will need to contract with such organizations. This will be especially difficult for us in trying to implement a managed benefit for almost four million members. Should we decide to select a behavioral health care partner, few of them have nationwide networks of behavioral health care providers available, and certainly none of them handles any groups with an enrolled population of our size. Should we choose to develop that capacity internally, we would require our 52 independent Blue Cross and Blue Shield Plans to develop this capacity and, if necessary, form networks by 2001. With either approach, one consequence would undoubtedly be controlled access to a reduced network of providers for our enrollees.

With regard to the cost implications of such a mandate, I will only say that, with enhanced benefits and no limits, even in a managed environment, there will be an increase in health care costs that must be borne by the enrolled population.

Further Benefit and Administrative Issues

While the call letter draws attention to specific program-wide initiatives for the coming year, there are of course other issues affecting the FEHBP in general that are not addressed in the call letter, but are of special concern for the Service Benefit Plan. In accordance with your invitation to comment on other matters concerning the FEHBP, I would like to discuss two issues about which I have testified before you previously, and yet which remain arguably the two most important issues challenging our participation and success in the program.

Cost Accounting Standards

One area of great concern to us is the Administration's continuing efforts to impose the cost accounting standards on carrier contracts in the FEHBP. These standards, developed primarily for contractors doing business with the Department of Defense, are promulgated by the Cost Accounting Standards Board. This Board is an entity with the Office of Management and Budget.

As you know, upon the request of this Subcommittee and the full Committee on Government Reform, the Congress included a provision in the Omnibus Appropriations Act of 1998 exempting carrier contracts in the FEHBP from the application of the cost accounting standards. The Administration, specifically, the Office of Management and Budget, opposed this provision at the time even though OPM was on record as recognizing the inherent difficulties in attempting to fit these standards to insurance contracts and had earlier requested the Cost Accounting Standards Board to grant a delay in application. The President's Fiscal Year 2000 Budget proposes to delete this exemption.

The Blue Cross and Blue Shield Association actively sought the exemption last year when we concluded, after an exhaustive analysis, that the cost accounting standards are fundamentally incompatible with, and inappropriate for, our health insurance systems. There are many technical reasons why the cost accounting standards don't make sense for FEHBP contracts and we have provided extensive justification for our position to this Subcommittee, other Congressional bodies, the Cost Accounting Standards Board Review Panel and to OPM.

For the purposes of this hearing let me simply note the obvious: In the Service Benefit Plan, federal enrollees use the same provider networks as other subscribers to commercial coverage offered by our local Blue Cross and Blue Shield Plans. Because of this, the Government also shares in the deep discounts that Blue Cross and Blue Shield Plans have been able to negotiate with providers. Our basic insurance company operations, such as claims processing, payment processing, provider contracting and utilization review, are largely indistinguishable for the Service Benefit Plan.

Truly by simple measures of common sense, if not by some of the arcane rules of government procurement, there is no government contract that is more of a commercial item acquisition than the contract for health insurance provided to federal enrollees under the Service Benefit Plan.

Because the Blue Cross and Blue Shield Plans cannot practicably segregate their FEHBP business (which accounts for only about five percent of the typical Plan's book of business) from their commercial business, the cost accounting standards cannot simply be applied just to the FEHBP portion. Accordingly, our plans would have to restructure their entire accounting systems to comply with the cost accounting standards. This would require them to group costs in ways that would cause adverse impacts for the management of their much larger commercial business. This simply cannot be justified as a rational business

decision and the implications of continuing to try and impose the cost accounting standards would cause many of our Plans to reassess their participation in the Service Benefit Plan. For these reasons, the Blue Cross and Blue Shield Association, as the agent of the Plans, cannot sign a contract with OPM that contains a cost accounting standards clause or that otherwise applies cost accounting standards coverage.

As I indicated earlier, we arrived at this position only after much study and only after seeking ways to apply the cost accounting standards to our existing accounting systems. Moreover, discussions with OPM and other carriers over the past several months have not produced any substantive areas where applying the cost accounting standards would add value to the FEHBP. Thus, our position has been reaffirmed; we are convinced that the statutory exemption that the Congress so wisely provided last year is not only appropriate, but necessary. Given the Administration's reluctance to recognize the inappropriateness of applying the cost accounting standards to our contract as evidenced by the proposal to delete the exemption, we are also convinced that congressional intervention is required. Once again, we ask for your assistance in retaining this vital statutory exemption.

Prescription Drug Benefits

A second area of significant concern is the lack of sufficient flexibility to adapt our benefit structure to changing trends in a timely manner. An important case in point is our prescription drug program.

The cost trends for prescription drugs continue to outpace by far all other benefit cost trends. The demand for new, expensive drug therapies continues to increase, fueled in part by direct-to-consumer advertising. Other factors, such as the aging of our enrollee population, also contribute to rising costs, as I testified before this Subcommittee last year. And in the Service Benefit Plan, we continue

to experience wastage and high utilization that is encouraged by the availability of "free" drugs for some enrollees. We have sought to control our costs by introducing cost sharing for these enrollees, but for the past two years, OPM has denied our requests to address these issues in this manner.

To be precise: our proposals to introduce cost-sharing in our mail pharmacy program for members with Medicare have been rejected repeatedly, despite our having provided ample, unprecedented documentation of the need for this change. While we have sought to minimize unnecessary utilization and to assure that necessary cost-sharing was spread across our entire covered population, the repeated denials simply maintain the free drug benefits for the Medicare population while increasing the burden on active employees. Moreover, the rejections of our benefit proposals are especially disappointing when we have seen other carriers permitted to alter their benefit designs in the same way that we have sought without success. Now, not only do we have reason to question the existence of a "level playing field" for all carriers, but the benefit adjustments now required are larger than they would have been had we been permitted to respond to rising drug trends in a timely manner.

The rules by which the FEHBP operates have always treated benefit negotiations as confidential between the carrier and OPM, for obvious reasons. We don't want to, or intend to, violate these rules here. But we believe that responsible stewardship of our responsibilities to all of our enrollees dictates that we alert the Congress to the growing, and troubling, lack of flexibility in benefit design.

Final Comments

The Blue Cross and Blue Shield Association is very proud of the role it has played in helping to make the Federal Employees Health Benefits Program a success. And as we approach the twenty-first century, we know that keeping the program as successful as it has been for nearly forty years will require

extraordinary stewardship by all parties responsible for its management, operation and service delivery. In that regard, it is apparent from our testimony today that we are growing increasingly concerned about the direction in which the FEHBP appears to be heading.

The fundamental strength of the FEHBP has been derived from a number of important features:

- The ability of enrollees to select from a number of competing health plans that will best meet their health care needs;
- The ability of carriers to compete on a level playing field and to bring needed and attractive products to the marketplace; and
- The ability of program administrators to make intelligent decisions, consistent with law and regulation.

These features must not be eroded by what appears to be the increasing tendency toward overly prescriptive program administration, regulatory rigidity and mandated coverage.

The FEHBP is widely admired in the health care world and, indeed, is viewed by many as a model of a successful consumer-choice program. As we move into the twenty-first century, it is crucial that we preserve and enhance the features that have ensured its success.

Thank you. Once again, on behalf of the Blue Cross and Blue Shield Association, I appreciate the opportunity to come before you and I will be pleased to answer any questions you may have.

Mr. SCARBOROUGH. Mr. Harnage has a flight that he has to catch at 1. Why don't you go ahead and we will take your testimony now, and then we will go back to Dr. Braun. If you can stay through his testimony also, I will ask panel members to direct their questions to you, and you just stay as long as you can.

Mr. HARNAGE. I appreciate that.

Mr. SCARBOROUGH. If that works for you.

Mr. HARNAGE. It works for me.

Mr. SCARBOROUGH. All right, Mr. Harnage.

Mr. HARNAGE. Thank you very much, Mr. Chairman. It's a pleasure to see you this morning, and I appreciate the opportunity to you and the subcommittee members to testify on this important issue this morning. I am the national president of the American Federation of Government Employees, AFL–CIO, and represent a little better than 600,000 Federal and DC government employees.

I know that my written comments will be submitted for the record and I will simply try to summarize this morning. Many people point to the Federal Employees Health Benefits Program as a model health insurance program. But I assure you that AFGE's perspective is the program is anything other than a model.

Although, we know that health care costs have gone up everywhere, we also know that the program costs have gone up far more than—much more than they should have, and Federal employees have had to shoulder much more of the costs and increased costs than they should have.

I want to focus my comments this morning on three related issues within the Federal Employees Health Benefits Program. The first issue is the premium inflation. The second issue is the need to make sure that OPM obtains from the program contractors the cost accounting information necessary to verify the accuracy of the bills they submit. These accounting standards affect all businesses which sell services to the government and are important safeguards against contractors overcharging for anything from health care services to fighter aircraft.

The third issue is our continuing effort to convince OPM to permit employee representatives to play a more important and active role in annual negotiations with program carriers over benefits and premiums as well as quality standards.

This is a clear case where the government and its unions have a mutual interest in a partnership to create a program that works better and costs less. I hope the members of this subcommittee will support our efforts in this area.

Over the past 2 years, the premium—program premiums have risen an average of more than 18 percent; in 1998, it was 8.5 percent; in 1999, it was 10.2 percent. And experts have warned that we are in for more of the same.

Instead of pledges to bring this inflation under control, our stern warnings to the insurance companies that the program will not tolerate a repeat of the 1980's decade-long nightmare of double-digit increases. All we hear from OPM are vague repetitions of the industry's own propaganda.

What it amounts to is blaming Federal employees, the victims of this inflation, for causing the inflation. The program requires Federal workers to shoulder an usually high cost-sharing burden when

compared to other larger employer-sponsored plans, both private and public sector. We need serious long-term relief from these costs.

Federal workers who have been continually denied the full pay raises due to them are now expected to continue to pay the full amount of every program premium increase OPM approves.

This brings me to the subject of the government's cost accounting standards. In cases where cost data supplied by contractors is used to negotiate contract prices or reimbursement, the government has to be able to verify the accuracy of this cost data.

The method for doing this is a rigorous application of cost accounting standards. Experts in this area use a rule of thumb estimate that the government saves about 5 percent of expenditures as a result of these standards; yet one carrier in the program managed to insert in last year's omnibus spending bill, a free ride for 1999.

You heard right: there are no standards governing the measurement, assignment, and allocation of costs to the program's experienced rated contracts.

Instead of allowing this 1-year exemption to continue or to become permanent law, I urge the subcommittee to insist that OPM and the carriers resolve any disputes on this issue so that Federal workers can be assured that all unnecessary costs will be eliminated.

Despite the fact that the program's financing structure requires Federal employees to pay at least a quarter, but on an average 28 percent of premiums, in addition to substantial out-of-pocket copayments, we are denied any meaningful voice in setting the program's benefits or its prices. AFGE has developed an excellent track record in working with Congress and other agencies throughout the government to bring about changes which are beneficial to the government and employees alike.

FEHBP is a prime example of a program which could benefit from serious employee input. One of the main issues OPM highlighted in this year's call letter to carriers, concerns the details of covering the President's executive memorandum on the patient's bill of rights. That is primarily an issue of enrollees in managed care.

Let me say that I appreciate Congressman Cummings' inquiry into our participation with the previous person testifying. He did, prior to the testimony, give me an invitation that he did want to work with us more closely; but I assure you, his idea of us working more closely is far from what my idea is.

I'm not looking for formal consultation. I'm looking for full participation at the table when we talk about and when we review the data and talk about the benefits and talk about the price increases. Consultation doesn't get us anywhere.

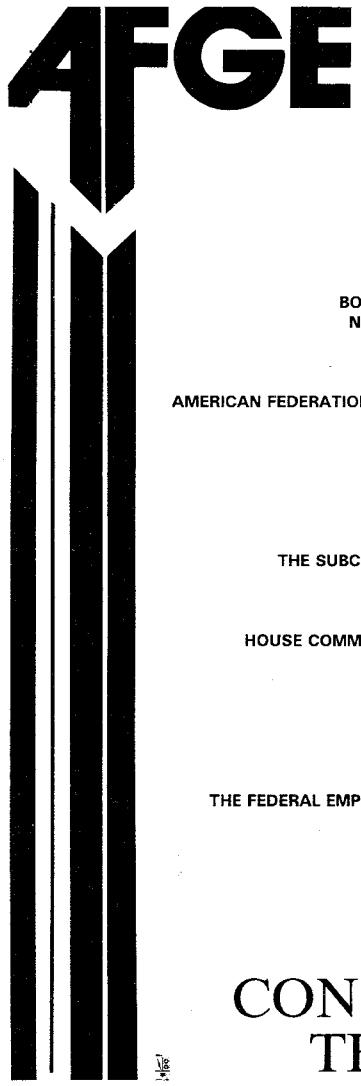
And on the issue of including the view of Federal workers in setting quality standards, OPM's approach has been to conduct an annual Gallup poll of customer satisfaction. That in no way substitutes for us being at the table, able to deal with the rising costs,

both to the Government and to the Federal employee on costs of this benefit program.

That concludes my statement. I will be happy to answer any questions that you might have.

Mr. SCARBOROUGH. Thank you, Mr. Harnage.

[The prepared statement of Mr. Harnage follows:]



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STATEMENT

BY

BOBBY L. HARNAGE, SR.
NATIONAL PRESIDENT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES (AFL-CIO)

BEFORE

THE SUBCOMMITTEE ON CIVIL SERVICE

HOUSE COMMITTEE ON GOVERNMENT REFORM

REGARDING

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

MAY 13, 1999

CONGRESSIONAL TESTIMONY

Mr. Chairman and Members of the Subcommittee: My name is Bobby Harnage, and I am the National President of the American Federation of Government Employees, AFL-CIO (AFGE). On behalf of the more than 600,000 federal and District of Columbia employees our union represents, I thank you for the invitation to testify today regarding our concerns about the Federal Employees Health Benefits Program (FEHBP).

FEHBP is our nation's largest employer-sponsored health insurance plan. It currently covers roughly nine million active and retired federal employees and their dependents. The FEHBP is often touted as a model for Medicare reform, or CHAMPUS reform, or even, at one point, national health care reform.

But from AFGE's long and unpleasant experience with double-digit premium increases, which in many cases have imposed cost increases to workers that have been larger than annual salary increases; the disappearance of popular plans, the unpredictable shifts in benefits from one year to the next, and the lack of meaningful input from our union into what the program should look like, FEHBP seems like anything *but* a model.

FEHBP has many serious flaws; some are structural, and some are more political in nature. Each of these flaws makes the program more expensive than it should be both for the government and for federal employees and

retirees. The reforms AFGE seeks would serve to lower the program costs without reducing available benefits.

This year's average premium increase of 10.2 percent follows a 1998 average premium increase of 8.5 percent. These numbers reflect the average increases of prices charged by plans. The fact that workers are forced to switch into less expensive and less comprehensive plans in response to these sharp premium increases should not be used to obfuscate the facts regarding FEHBP's uncontrolled price inflation. Relief from these skyrocketing FEHBP premiums is an extremely high priority for AFGE.

There are three related problems with FEHBP upon which I would like to focus today. The first is premium inflation. The second is the need to ensure that the Office of Personnel Management (OPM) has the cost accounting information necessary to determine the accuracy of the bills submitted by FEHBP carriers. These accounting standards affect all businesses which sell services to the U.S. government and are an important safeguard which serve to prohibit contractors from over-charging the federal government. The third is the continuing refusal on the part of OPM to permit employee representatives to play a more active role in the annual negotiations with the FEHBP providers over benefits and premiums.

Why are FEHBP Premiums Rising So Fast?

In September 1998, when OPM announced the 1999 premium increases, it exhibited a curious lack of concern regarding the fact that for the second year in a row, federal employees would face enormous increases in their premium costs. Federal employees were simply advised to respond to the higher premiums by switching to lower-cost (and lower-benefit) plans. OPM repeated the health industry's routine bromides and justifications for the increases. The message was essentially that the fault lay with federal employees themselves. Premiums were rising so fast, OPM explained, because we were aging, and using expensive prescription drugs, and using too much mental health care.

Such a line of reasoning raises several questions. *Why* are prescription drugs so expensive? *Why* are FEHBP plans charging such high prices for prescription drugs to the largest health care plan in the country? Why do the same drugs cost more here in the U.S. than they do in France and England? Federal employees and others who are forced to pay exorbitant costs for prescription drugs hardly set those prices. Pharmaceutical companies charge what the market will bear, often passing along to American consumers "research costs" which the federal government subsidized in the first place.

In the financial press, we read that Wall Street is putting pressure on health insurance companies and corporate health care providers to bring costs

down and profits up. We read of consolidation in the health care industry which creates the market power for plans to dictate prices. AFGE is forced to ask whether OPM, which is charged by the federal government to negotiate with FEHBP's plans and insurance companies on our behalf, is pressing hard enough to obtain the best benefits at the lowest possible price.

There is ample evidence that when it comes to oversight on government health care spending, the right hand appears not to know what the left hand is doing. A study conducted by the Health and Human Services Department which was publicized in November 1998 found that Medicare spent more than $1 billion per year than it should on prescription drugs. The study compared the prices paid by the Department of Veterans' Affairs and Medicare for 34 often-prescribed drugs. Of course the DVA purchases drugs directly from manufacturers or wholesalers and Medicare has a reimbursement financing system. Nevertheless, the study illustrated that there is no single market price for prescription drugs. Rather, drug prices vary substantially based upon what the seller can force the buyer to pay.

The government is in a good position to negotiate favorable terms for the 38 million Americans who are beneficiaries of Medicare; likewise, it is in a good position to negotiate favorable terms for the more than 9 million Americans who purchase their health insurance through FEHBP.

Another reason we have to believe that OPM justification of the health insurance companies' demands with regard to FEHBP premiums are specious is that the very prescription drugs which are blamed for premium inflation are marketed as low cost alternatives to hospitalization and surgery. Many of the most expensive prescription drugs which have been introduced in recent years obviate the need for hospital admissions and minor surgeries, items which have always been at the top of the list of factors driving medical cost inflation.

The indignities visited upon federal employees and other Americans who were forced into managed care's notoriously restrictive delivery systems appear to have been suffered in vain. The period of cost stability and/or cost reduction as the payoff for fewer choices and less freedom seems to be over, at least for FEHBP. In 1999, the premium increases for several of the largest managed care plans rose much faster, in the case of some local plans in the Washington, D.C. area, at twice the rate of the indemnity plans.

Another specious explanation for rapid and large growth in FEHBP premiums which has been offered by OPM and the insurance companies is that FEHBP is at the mercy of the same forces which have driven up health care costs throughout the country. According to the Health Care Financing Administration (HCFA), real per capita spending on health care has risen by 2.6 percent between 1996 and 1998, and prescription drug spending has

risen by 6.6 percent. These data reflect prices charged to consumers, **not** costs borne by pharmaceutical companies or insurance companies. If the claims made to FEHBP's carriers were rising faster than these aggregate rates, there must be an explanation which is unique to FEHBP. Such an explanation has not been forthcoming.

Indeed, in order to purchase health care services for employees on the most favorable terms possible, most large private sector firms do not purchase health insurance the way the federal government does through the FEHBP. Instead, they self-insure and contract with third parties to handle claims administration. It is ironic that the federal government, which runs several of the largest health insurance programs in the nation, including FEHBP, claims all the same problems as those of individual policyholders and small businesses.

Again, it must be remembered that many of the most costly prescription drugs, for example, those which reduce cholesterol, save insurers money by helping patients avoid bypass surgery, heart attacks, and stroke -- events which require hospitalization which remains the costliest form of health care.

Studies conducted by the General Accounting Office (GAO) and the Congressional Research Service (CRS) have repeatedly shown that the benefits received by federal employees under FEHBP are inferior to those

provided by large private sector employers. Large private employers spend roughly $1,000 more per employee per year on health insurance, and that differential does not represent superior benefits; it represents a superior financing formula.

Federal employees need relief from the skyrocketing premiums charged by FEHBP carriers. The relief can and should come in many forms, but it should include a premium-sharing formula that follows the standards set in large private sector firms, greater scrutiny over the costs allocated to the FEHBP by FEHBP's plans, and an improvement in the terms on which health insurance companies and health plans are allowed to participate in the FEHBP.

Government Cost Accounting Standards (CAS) and FEHBP

Agencies use, or are supposed to use, cost accounting standards to ensure the accuracy of bills submitted by contractors for cost-based and cost-reimbursement contracts. If cost data supplied by contractors is to be used to negotiate contract prices or reimburse contractors for the costs of their performance, then agencies must be able to verify the accuracy of the cost data through rigorous application of the standards.

Estimates about the savings that are generated by the use of cost accounting standards vary. However, some experts use a "rule of thumb"

estimate that the government saves 5 percent of applicable expenditures. For example, in an essay which appeared last year in Legal Times, a publication that nobody would ever accuse of spreading union propaganda, Charles Tiefer, a University of Baltimore Law School Professor, and Danielle Brian, executive director of the Project on Government Oversight, wrote that the "5 percent estimate" means that the use of CAS "saves the government at least $7 billion a year."

At the behest of a major FEHBP carrier, a provision was inserted in last year's massive onmibus spending bill that negated for the duration of the fiscal year all cost accounting standards for FEHBP – both those that had been applied to the program as well as those that should have been applied but were not because of administrative indifference. Apparently, carriers contended that complying with cost accounting standards was unduly onerous. It must be pointed out, however, that HCFA and the Department of Defense use cost accounting standards in the administration of Medicare and Tricare/CHAMPUS, often with the compliance of the very same carriers who are protesting the use of cost accounting standards for FEHBP.

This legislative effort short-circuited the normal administrative process for resolving such issues through the Cost Accounting Standards Board, in OMB. Contrary to much misinformation, the Board was not rigidly opposed to any and all changes to the use of CAS by OPM for FEHBP carriers. In fact, the

Board showed great flexibility, granting OPM a last-minute waiver last year for several standards.

As a result of this obscure legislative provision, however, there are now no standards governing the measurement, assignment, and allocation of costs to FEHBP experience-rated contracts. Instead, the government relies on meaningless persuasive tactics to keep contractors' costs down.

The ostensible purpose of this provision was to give OPM and the carriers time to resolve their differences. We understand that very little progress has been made, despite OPM's conciliatory approach, and suspect that the carriers will now seek an additional extension or perhaps even a permanent exemption. We urge the subcommittee to oppose such an effort and instead to encourage OPM and the carriers to seek the assistance of the Board to resolve outstanding issues.

AFGE Seeks a Greater Voice in FEHBP

The current structure of the FEHBP gives federal employees virtually no meaningful voice in the setting of premiums and benefits. This is true despite the fact that FEHBP forces federal employees and retirees to pay on average 28 percent, but at least 25 percent of premiums (and in some cases as much as 45 percent) in addition to substantial out-of-pocket copayments. AFGE would like to work with OPM in the annual negotiation process with

FEHBP's health plans so that we can be assured that the terms on which health insurance is made available to federal employees are as favorable as possible.

Working together on ways to keep FEHBP's costs under control seems to us to be natural and appropriate. AFGE has developed an excellent track record working with OPM and other agencies throughout the government as a full partner in implementing new strategies for a "government that works better and costs less. "We believe that AFGE and the federal government have a mutual interest in working together to make certain that the benefits made available to federal employees under FEHBP are of the highest quality at the lowest possible costs.

The annual "Call Letter" from OPM to FEHBP carriers sent out in April 1999 advises plans on the specifics of conforming to the President's Executive Memorandum regarding the Patients' Bill of Rights. Although AFGE is pleased that FEHBP's carriers will be expected to meet these standards, it is significant that neither AFGE nor any other federal union was given the opportunity to express our views and interests regarding what should be included in such a set of quality standards. Interestingly, OPM insisted that the quality standards guaranteed in the Patients' Bill of Rights played no role in causing the enormous rise in FEHBP premiums in the last two years.

Indeed, in the current Call Letter, reference is made to a cost of $.25 per enrollee for adherence to the standards.

Quality in health care is notoriously difficult to define. The Call Letter quotes the Institute of Medicine's definition as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." If implementing standards designed to meet these goals cost FEHBP's carriers virtually nothing, are we to conclude that all the plans were already meeting these standards prior to the President's Executive Memorandum? Were all the changes made to comply with the standards cost-neutral?

It seems unlikely that enforceable and meaningful quality standards would cost nothing. Some of the standards include allowing women continuity of care with OB-GYN's through the end of pregnancy and post-partum even if the managed care plan severs its relationship with that provider prior to that time. The referral process for approval for emergency services and access to specialists for chronic conditions are also included in the Patients' Bill of Rights. If FEHBP participants had previously had claims for emergency-room visits denied for lack of adherence to pre-Bill of Rights standards, claims which would now have to be honored, should this not affect costs?

The Call Letter includes OPM's summary of the results of the customer satisfaction surveys it hires the Gallup Organization to conduct each year. Focus Groups conducted by a polling organization are no substitute for meaningful input by federal employees' elected representatives, i.e. unions.

There is no valid rationale for excluding AFGE from negotiations with FEHBP's health insurance carriers on issues ranging from quality assurance to covered benefits to premiums. In the jargon of the health insurance world: We are purchasers, we are consumers, and we are healthcare quality advocates. AFGE has an economic and representational interest in playing a more meaningful partnership role in FEHBP, and we request this Subcommittee's assistance in fulfilling that role.

Recently OPM invited AFGE to a briefing where efforts to establish a plan to make private long term care insurance available to federal employees were described. Representatives from OPM went to great lengths to explain that unions were being included at the very outset of planning. Why? Federal employees would be paying the premiums, they explained, and thus would have an enormous interest in what types of benefits should be made available, what types of restrictions should be included in the contracts with insurance companies, what protections and appeal rights claimants should be guaranteed, among others.

If the concerns expressed by OPM are true for long-term care insurance, they are just as true for health insurance under FEHBP. Indeed, AFGE feels that the issue is even more urgent for FEHBP because health insurance is needed by all federal employees, even if at least 25,500 who are currently eligible but do not purchase coverage through FEHBP because they cannot afford it. In contrast, private long-term care insurance is something relatively few federal employees would or should purchase. And even though long term care insurance policies under the President's plan would be paid for entirely by federal workers and thus cannot be considered a "benefit," they would likely cost less than federal workers currently pay for FEHBP.

Conclusion

Far from being a model for others to emulate, FEHBP has several serious flaws. Its financing formula forces federal workers to bear such high costs that 25,500 who are otherwise eligible to participate have no insurance. The government is squandering its own considerable bargaining power by clinging to a structure which forces both it and its employees to pay too much for the benefits we purchase.

The issue of Cost Accounting Standards is but one of many instances where the federal government and its employees, through more rigorous oversight of FEHBP's contractors, could save money without sacrificing needed benefits.

Finally, I urge the Members of this Subcommittee to require OPM to grant federal employee unions greater input into the annual negotiations with FEHBP's insurance carriers. AFGE members have a serious interest in making FEHBP the best health insurance plan in the nation, and getting the absolute best quality and most comprehensive coverage for our health care dollars. We stand ready to work in partnership with OPM toward this goal.

This concludes my statement. I will be happy to answer any questions you may have.

Mr. SCARBOROUGH. Dr. Braun.

Dr. BRAUN. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, my name is Dr. Joseph L. Braun; and I am the chief medical officer of the George Washington University Health Plan in Bethesda, MD. The GW Health Plan has over 25,000 members enrolled in the Federal Employees Health Benefits Program.

Today, I will be testifying on behalf of the American Association of Health Plans, the principal national organization representing health maintenance organizations and preferred provider organizations and similar network-based plans in the United States. A significant number of AAHP member-plans participate in the FEHB program.

Given that the FEHB program serves as a model for health coverage, we urge caution in interfering with this program's success. The success depends in large part upon the flexibility Congress accords to the OPM in administering the program.

AAHP and its member-plans have a long-standing relationship with the Office of Personnel Management and have worked closely with OPM in the past years to resolve benefit, administrative, and other issues.

We look forward to continuing our partnership with OPM to improve the FEHB program and to relay our concerns about the carrier letter for proposed benefits and rate changes in the contract year 2000.

Between 1998 and 1999, 95 health plans decided not to renew their contracts with the FEHB program. While many of these terminations were attributable to health plan consultations and acquisitions, some plans terminated their contracts because of insufficient FEHB program enrollment, a noncompetitive FEHB program premium, and unpredictable utilization risk from a small number of enrollees.

AAHP and its member-plans are concerned that many of the requirements imposed by current bills in Congress and other recently passed mandates would micromanage health plan operations and freeze medical practice and present day patterns.

As a result, these legislative proposals, if enacted, would significantly drive up health care costs and the number of uninsured Americans while doing nothing to improve and, in fact, potentially reducing the quantity and quality of care.

The President's patient's bill of rights—let me just say a few things about this. By working in collaboration, OPM and health plans have insured that many of the protections contained in the President's health care consumer's bill of rights could be implemented smoothly.

However, there are several requirements which may be especially difficult for health care plans to implement. We caution Congress that administrative and benefit mandates have the danger of making the FEHB program unwieldy, more expensive, and less responsive to the beneficiaries' needs.

One example of this is the area of information disclosure. Health plans routinely make information readily available to enrollees. However, we believe the OPM's information disclosure requirements are overly broad and burdensome. Some information such as

disenrollment rates may be difficult for health care plans to keep current.

And while health plans are committed to informing the members upon requests about how participating physicians are paid, we caution that such information may be difficult for members to understand and may, therefore, lead to further confusion.

The second area of concern relates to transitional care. Health plans believe that patients who change from one provider to another included from a nonnetwork provider to a network provider should be assisted in making this transition as easy as possible.

OPM's interpretation of the President's bill of rights could impose unnecessary requirements in this area.

Many health plans already have voluntary procedures to facilitate the transfer of care from one practitioner to another when in the best interests of the patient.

Now let me turn to the topic of assessing quality health care. We support OPM's efforts to improve the FEHB program through enhanced quality measures. In an effort to reduce the administrative burden on plans, OPM decided to adopt a health plan and employee data information set more popularly known as HEDIS as its quality measure.

While we greatly appreciate the use of HEDIS, we have two concerns. First, the OPM requires that health plans collect additional HEDIS data specifically for children, but a single plan may not have a large enough survey pool for results to be statistically valid.

Furthermore, while the OPM has provided each plan $7,000 to cover the costs of this survey, this amount does not begin to cover the actual costs of such a survey.

In the issue of provider contracts, let me just say a few words. OPM encourages health plans to provide access to nonphysician providers when appropriate; however, we are concerned with this lack of adequate accreditation standards for nonphysician providers.

While, in some cases, nonphysician providers may broaden the health care delivery system for plan members, many such providers may not contract with managed-care organizations, and additionally some nonphysician providers, such as nurse midwives, may be required to be under the supervision of a licensed physician under State law.

The President's plain language initiative is such another example of how OPM is working with the health plans to improve the quality of care received by FEHB members. The plain language initiative facilitates better consumer understanding of health care plan options and benefits.

OPM has worked closely with the AAHP and its member-plans to revise the FEHB program brochure in plain language. Let me just say AAHP member-plans are working hard and succeeding at providing access to high quality care for their FEHB program members.

We cannot forget, however, that one of the greatest barriers of access to care is affordability, even in the FEHB program market. Health plans have played a key role in keeping health care affordable for millions of Americans by focusing on continuous quality

improvement and developing innovative strategies to provide patients with the care they need.

In order to promote affordability, to improve access and to do no harm, Congress and the OPM must continue to allow health plans the flexibility to meet the needs of the Federal employees. We caution Congress against the urge to micromandate and manage programs, an urge that can alter the FEHB program's role as the national standard-bearer for health care coverage.

I thank the ladies and gentlemen for this opportunity to speak on this vital subject.

Mr. SCARBOROUGH. I thank you, Dr. Braun.

[The prepared statement of Dr. Braun follows:]

Statement on

FEHBP: OPM's Policy Guidance for Year 2000

By Dr. Joseph Braun, M.D., J.D., M.P.H.
Chief Medical Officer
The George Washington University Health Plan, Bethesda, MD
on Behalf of
The American Association of Health Plans

Before the
House Civil Service Subcommittee of the Committee on Government Reform

May 13, 1999
Washington, DC

Mr. Chairman and members of the Committee, my name is Dr. Joseph Braun, and I am chief medical officer of the George Washington University Health Plan in Bethesda, Maryland. The GW Health Plan has over 25,000 members enrolled in the Federal Employees Health Benefits (FEHB) program.

I am testifying on behalf of the American Association of Health Plans (AAHP), the principal national organization representing health maintenance organizations (HMOs), preferred provider organizations (PPOs), and similar network-based plans. A significant number of AAHP member plans participate in the FEHB program.

Given that the FEHB program serves as a model for health coverage, we urge caution in interfering with the program's success. This success depends, in large part, upon the flexibility Congress accords to OPM in administering the program.

AAHP and its members plans have a longstanding relationship with the Office of Personnel Management (OPM) and have worked closely with OPM in past years to resolve benefit, administration, and other issues. We look forward to continuing our partnership with OPM to improve the FEHB program and to relay our concerns about the Carrier Letter for proposed benefit and rates changes in contract year 2000.

Between 1998 and 1999, 95 health plans decided not to renew their contracts with the FEHB program. While many of these terminations were attributable to health plan consolidations and acquisitions, some plans terminated their contracts because of insufficient FEHB program enrollment; a noncompetitive FEHB program premium; and unpredictable utilization and risk.

AAHP and its member plans are concerned that many of the requirements imposed by current bills in Congress and other recently passed mandates would micromanage health plan operations and freeze medical practice in present day patterns. As a result, these legislative proposals, if enacted, would significantly drive up health care costs and the number of uninsured Americans, while doing nothing to improve, and in fact potentially reducing, the quality of medical care.

President's Bill of Rights

By working in collaboration, OPM and health plans have ensured that many of the protections contained in the President's Health Care Consumer's Bill of Rights could be implemented smoothly. However, there are several requirements which will be especially difficult for health plans to implement. We caution Congress that administrative and benefit mandates have the danger of making the FEHB program unwieldy, more expensive, and less responsive to beneficiaries' needs.

One example of this is in the area of information disclosure. Health plans routinely make information readily available to enrollees; however, we believe OPM's information disclosure requirements are overly broad and burdensome. Some information, such as disenrollment rates, may be difficult for health plans to keep current. And while health plans are committed to informing their members, upon request, about how participating physicians are paid, we caution that such information may be difficult for members to understand, and may lead to further confusion.

The second area of concern relates to transitional care. Health plans believe that patients who change from one provider to another – including from a non-network provider to a network provider – should be assisted in making this transition as easily as possible. OPM's interpretation of the President's Bill of Rights could impose unnecessary requirements in this area. Many health plans already have voluntary procedures to

facilitate the transfer of care from one practitioner to another when in the best interest of the patient.

Quality Healthcare

Let me now turn to the topic of assessing quality health care. We support OPM's efforts to improve the FEHB program through enhanced quality measurement. In an effort to reduce the administrative burden on plans, OPM decided to adopt the Health Plan and Employer Data Information Set (HEDIS) as its quality measure. While we greatly appreciate the use of HEDIS, we have two concerns. First, OPM requires that health plans collect additional HEDIS data specifically for children. But, a single plan may not have a large enough survey pool for results to be statistically valid. Collecting this supplemental information is also costly. While OPM has provided each plan $7,000 to cover the costs of the children's survey, this amount does not begin to cover the actual costs of the survey.

Provider Contracts

OPM encourages health plans to provide access to non-physician providers when appropriate. However, we are concerned with the lack of adequate accreditation standards for non-physician providers. While in some cases non-physician providers may broaden the health care delivery system for plan members, many such providers may not contract with managed care organizations. Additionally, some non-physician providers,

such as nurse midwives, may be required to be under the supervision of a licensed physician under state law.

Customer Service

The President's Plain Language initiative is just one example of how OPM is working with health plans to improve the quality of care received by FEHB enrollees. The Plain Language initiative facilitates better consumer understanding of health care options and benefits. OPM worked closely with AAHP and its members plans to rewrite the FEHB program brochure in plain language.

AAHP member plans are working hard—and succeeding—at providing access to high quality care for their FEHB program members. We cannot forget, however, that one of the greatest barriers to access to care is affordability, even in the FEHB program market. Health plans have played an key role in keeping health care affordable for millions of Americans by focusing on continuous quality improvement and developing innovative strategies to provide patients with the care that they need. In order to promote affordability, to improve access, and to do no harm, Congress and OPM must continue to allow health plans the flexibility to meet the needs of federal employees. We caution Congress against the urge to micro-mandate and manage the program, an urge that could alter the FEHB program's role as the national standard bearer for health care coverage.

Mr. SCARBOROUGH. Mr. Mica has a meeting coming up, and I would like him to begin the questions. Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman. Welcome back, Mr. Gammarino. And Mr. Gammarino, my interest has been to bring down the costs for Federal employees. I happen to be a Federal employee. I am happy to participate in one of those, and I am not interested in increased costs. You ought to hear my wife when the costs go up; it's not a pleasant scene.

I am interested in benefits, and I represent a lot of senior citizens in central Florida and retirees—the benefits and the quality of care is very important to them.

I preface this question in light of that background. Has OPM ever invited you to suggest an innovative benefits package design that would help cut the costs of health care for our employees, for our retirees, and taxpayers while still providing high-quality coverage?

Mr. GAMMARINO. Before I answer that question, it's good to see you again.

Mr. MICA. Thank you.

Mr. GAMMARINO. Specifically, the answer to that question is no. But I don't know that that's OPM's job. I do think though——

Mr. MICA. Maybe you could provide to the committee, because you know Mr. Gammarino, you're probably the biggest coverers, aren't you? You cover the most Federal employees, retirees.

Mr. GAMMARINO. We cover the most Federal and retired employees.

Mr. MICA. And I think Mr. Harnage represents the most Federal employees. I would love to see you guys get together and sit down, even without OPM, because they might be a distraction, and you said you wanted to participate and come to us with an alternative, because you sure as hell aren't going to get it done through them. And it doesn't seem to be their objective.

Most of the things they come to us with drive up the costs. And you just heard testimony here of increasing costs. And if it's a patient's bill of rights that mandates these costs, if it's prescription drugs that account for the largest increase, we need to be looking at some alternatives that bring more people coverage and access at reasonable costs. So I would really appreciate if—and I'm asking you to work with us and maybe sit down with——

Mr. GAMMARINO. If I can just followup more specifically to your question. When I said they haven't asked, I really think it's our obligation. I think we do have roadblocks. You've pointed out many of them.

But the major one we need is flexibility of benefit design. It does no good to have any proposal if we have significant hurdles and roadblocks in terms of OPM accepting any innovative benefit design.

Mr. MICA. If you were going to look at the No. 1 area in which we could possibly have the potential for cutting costs, would that be the item that you would address, flexibility and design of the package?

Mr. GAMMARINO. Yes, it would, and it would be specifically on prescription drugs. I know everybody here has indicated such a sig-

nificant concern and our enrollees express that time and time again.

Mr. MICA. Mr. Harnage had complained that we had given a waiver for 1 year on the accounting standards. If we impose that, what is going to happen? And is there any way that the costs and other things that OPM has a way to verify them, check them now?

I mean, we want to do what he would like to do, but what's going to happen if we do the alternative? We've given you a waiver how can we ensure that we are getting that information or OPM is accurate?

Mr. GAMMARINO. Right. I would be pleased to address that question. First, a point of clarification, we have a permanent exemption relative to the cost accounting standards. It is not a 1-year waiver at all. Somebody is going to have to repeal that and hopefully they won't succeed.

Mr. MICA. If it was repealed, what would happen? And then the other thing, too, is since you have this permanent status, how is the Federal Government taxpayer and the Federal employees representative group assured that they are good provisions for OPM to check on these costs?

Mr. GAMMARINO. Right. I would be happy to answer that question. First, let's talk about costs. When it comes to the cost accounting standards in this program, first of all, we're only talking about, on average, 7 percent of the overall costs.

Ninety-three percent of the costs of this program are related to benefit dollars. Those are provider liabilities that are passed through the program that we actuarially rate for, so they would not be included in CAS at all. So that just leaves 7 percent.

Today, under the Federal Acquisition Regulations, which are commonly called the FAR, there are very specific cost accounting standards that we and other carriers have to abide by; and there's been previous testimony before the GAO panel on CAS last year that the agency has found over the last 39 years that those types of regulations that we have today are quite adequate to ensure that the government is being charged appropriately.

I might also add that we do have an administrative cap. Although it is a cost reimbursement program, we can never exceed that cap; and it's adjusted each year by inflation and by how well you do in the marketplace.

Mr. MICA. The final question. There has been some talk about the costs of the patient's bill of rights, and the President, I think, has said that it wouldn't cost much more to impose his patient's bill of rights, his proposal across the board and in a congressional mandate for all health care folks. There are some differences between what he's proposed at large and what FEHB has enacted.

What are those major differences, is the first part of my question. And then the second is, what would be the costs? I know at least one of those is to allow the suit of the carriers. What effect would that have on FEHB, and then again are we comparing apples and oranges here?

Mr. GAMMARINO. Well, I think from my perspective we are comparing apples to oranges. As my testimony indicates, the agency has been quite reasonable in terms of how they interpret, I guess, the overall design of the patient's bill of rights. And we do not see

that reasonableness necessarily in some of the legislation up on Capitol Hill today relative to the President's proposal.

So I would be very cautious about using any figures in terms of cost effectiveness relative to this program and transferring that over to the national scene.

Mr. MICA. Well, there are two major differences between most of the pending Federal legislation, I guess, external review and the right to sue——

Mr. GAMMARINO. Right.

Mr. MICA [continuing]. If they were instituted in the patient's bill of rights as it affects your program. Would we see another round of increases in cost?

Mr. GAMMARINO. I'm sure we would, Mr. Mica. But I don't have any figures to that effect.

Mr. MICA. OK. Thank you, Mr. Chairman.

Mr. SCARBOROUGH. All right. Thank you, Mr. Mica.

I would like to now turn it over to the ranking member, Mr. Cummings. And again, Mr. Harnage, any time you need to leave we certainly understand.

Mr. CUMMINGS. What time is your plane, Mr. Harnage?

Mr. HARNAGE. 1 o'clock.

Mr. CUMMINGS. You actually fly out at 1 o'clock? Let me ask you some quick questions, and then I think you need to go. I don't know where you're flying out of—BWI, the greatest airport known.

Mr. HARNAGE. Thank goodness it's out of National and I thought 3 hours would be enough. But I have some important business with the subcommittee. You can't always start on time, and I understand that.

Mr. CUMMINGS. Let me just get to—my questions are pretty simple. You said you want to be a player at the table, and I understand that. It makes a lot of sense. I'm trying to figure out—I mean I'm sitting here thinking—and I was listening to Mr. Mica and trying to figure out what it is that you think you all could bring to the table that would reduce benefits, and at the same time—I mean, not reduce benefits but reduce premiums, and at the same time have the kind of benefits that your members want and need.

And I guess I'm trying to figure out what—because I kind of get the feeling from Mr. Flynn, I can't speak for him, but I got the feeling, I wonder whether—as I listened to him, whether they even think you all have something to bring to the table that deals with those two situations. And I'm just curious as to what you see yourself and your organization bringing.

Mr. HARNAGE. Well, one thing we would bring is the employees' perspective. You know, what we see is not necessarily the dealing with one party at the table. We may very well be able to work with the providers and helping them reduce some restrictions that provide them a better way of delivery of service or less costly way of doing it, where they can't get past OPM.

Maybe the two of us can come in here and convince Congress where they need to make some changes legislatively in order to make the system work better, you know. So we would not always or necessarily be in opposition to what the providers want to do, and at the same time, would not necessarily be always opposed to what OPM is trying to do.

The problem is that we are not at the table, and it clearly appears to us that somebody is not doing all that can be done; and until we are convinced of that, we're always going to be critical of the program.

AFGE is not a stranger to the health benefit program. We were in the business at one time. We got out of it because of OPM playing their role in it. We decided it was better for us to get out of the business and try to make the program better, rather than stay in the business.

And to give you an example, we tried to come up with a Cadillac plan, but because our costs increased so much with the Cadillac plan, OPM turned it down on costs, even though our benefit was better than any other carrier and our cost was less than any other carrier.

It was turned down simply because the premium increase was too much, not that it costs more or that it wasn't, you know, worth the money.

So I know the bureaucracy of the government. It sometimes makes no sense in trying to provide services to its employees and to the taxpayers. And I think we can bring some common sense to the table.

Mr. CUMMINGS. I think it was you that said a little bit earlier ago a poll was taken by OPM trying to figure out satisfaction or whatever. What are you hearing from your employees, your members, with regard to the benefit package and where it stands right now, the benefits side of it?

Mr. HARNAGE. Well, the benefit side of it is fairly good, but the problem is that our people every year don't go shopping for the best benefits; they go shopping for what they can afford.

Mr. CUMMINGS. No doubt about that.

Mr. HARNAGE. No doubt about that. And the statistics show there's lots, thousands, of Federal employees who don't have any insurance because they can't afford it. So they're talking more about premium increases and they tell me about, yes, I did get a small pay increase, but my taxes went up and my health insurance premium went up; and I actually took $2 less home than what I had before I got the pay increase. You know, there are numerous examples of that.

Mr. CUMMINGS. Now Mr. Gammarino talked about one of the things that he would like to see is flexibility with regard to benefits. Am I right, Mr. Gammarino?

Mr. GAMMARINO. Yes, sir.

Mr. CUMMINGS. I mean, do you see that as something that would be helpful to you? I mean, is that something that you like?

Mr. HARNAGE. Well, again, we're talking about the provider to be able to market shop rather than the employee being provided a particular benefit. I think that's one of the problems in the Federal Government. Look how many participants, how many carriers we have in the Federal Government, that look for segments of the market where they can be successful and make a good profit.

We're not looking at what the Federal employee needs in health benefits and who wants to provide it and at what costs. We don't hesitate to study Federal employee jobs for privatization, for contracting out, supposedly because it saves money.

But we don't even think about that in the health industry. Why don't we have over 100 carriers? Why don't we come up with 4 or 5, maybe 6, plans so that Federal employees can choose what best benefits them and put that out there to the industry and say, OK, you guys, which one of you can provide this at the least cost?

How come we're not thinking about that in—privatization saves money. It works both ways.

Mr. CUMMINGS. Last question. You said in your statement that as far as long-term care insurance is concerned few Federal employees would or should have it. Can you just comment on that, since that's——

Mr. HARNAGE. Say that again.

Mr. CUMMINGS. Long-term care insurance.

Mr. HARNAGE. Long-term care insurance. And I really admire those that are trying to, you know, address this subject. I know you are, and you've been working with some of my staff and Mrs. Morella, as well, but it's hard for me to get enthused about the long-term care. I don't like to leave anybody behind.

And when we have Federal employees that can't even afford the basic health care, long-term care isn't going to help them at all because they can't afford that either.

And this is not a benefit to the Federal employee except for the fact it's a group-rated plan. They're still going to foot the entire plan, but it will be a group-rated plan and, therefore, supposedly lesser costs.

But with OPM's record in the other area, I, again, can't get too enthused that it is going to be done right.

One of the problems with the administration and one of the positive things about yourself and Mrs. Morella—the administration did not talk to us about the inclusion of long-term care and the Federal sector. They should have—if they really are partners they should have, you know, got us involved in the beginning, which you did and Mrs. Morella has done.

We're going to work with you. We think it's a good idea. We think it can work, but there are some things that we have to work out.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. SCARBOROUGH. Thank you, Mr. Cummings.

Mr. Harnage, before you leave, is there anything you would like to comment on, other than what you've commented on, regarding the testimony either of OPM or the testimony of the gentleman sitting to your right?

Mr. HARNAGE. I will hasten to get out of here, I'm getting a little nervous about that flight. But I do want to say I really appreciate this opportunity and finally having the opportunity to meet you, Mr. Chairman. I look forward to us meeting again and having some in-depth conversations about where you want to go and where we can help.

Mr. SCARBOROUGH. That's great. I appreciate you being here and certainly apologize for the delay in starting this and ask next time you're back up here if you will come by my office.

Mr. HARNAGE. We will do. Thank you, Mr. Chairman.

Mr. SCARBOROUGH. Thanks a lot. Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

I would like to ask Dr. Braun and Mr. Gammarino what their view is of why health care costs or premium costs arose at such a slower rate in the early 1990's than they are rising at today?

Mr. GAMMARINO. If I can take a first shot at that Mrs. Norton. In the early 1990's, all of the indices related to health care were relatively low. On the provider side we saw many of us, including Blue Cross and Blue Shield, get significant discounts from those providers, and we were able to pass those along to the consumer.

What has happened starting in the late 1990's is we've had a significant spike relative to prescription drugs. It's really that simple, and it's that localized. You can see it, OPM has seen it, I think every health plan has witnessed the same thing.

Ms. NORTON. Dr. Braun.

Dr. BRAUN. Yes, ma'am. I would like to echo Mr. Gammarino's comments about that. The early days of managed care were days when the major vehicle employed to lower costs was that of contracting; and most of the decrease in inflation was due to discounts and the elaborate patterns of contracting by the managed-care organizations.

Now, what we've seen is over the last 10 years, the increasing pressure on medical costs due to increased technology were able to do a lot, the fact that the population in general is aging.

And, finally, what I would say is a change in the definition of perception of what we consider to be health nowadays, we're doing a lot of things. We're covering a lot of things that we couldn't consider to be health—health in that sense.

The real challenge for managed care at this point lies in the fact that where the opportunities were to improve costs——

Ms. NORTON. Wouldn't consider to be health. What do you mean?

Dr. BRAUN. Things like Viagra, for one thing. There are a lot of things that are out there, that kind of life-style enhancing treatments. And these are things not only pharmaceutical but also in terms of mental health benefits and things like that. There's an old saying in the managed-care or, actually, in the medical profession that America is the only country that seems to believe that death is a preventable disease.

I mean, we really do spend an awful lot of time trying to take and not only improve, like we did in the past, the state of disease, but improve the state of health. And—by the same time, I mean we're seeing the companies coming along with things to improve appearance. I mean, you know, Retina A, things like Propecia, and things like that.

So there really is a lot of things out there that are really changing the perception of what we mean by health. Again, the true challenge for managed care nowadays is the fact that we are in a situation where there's variation, a lot of variation in managed—or medical care practices in the United States.

And Jack Lynnberg's work on the fact that, you know, you've got pneumonia in two towns in New England that are 15 miles apart and it costs four times as much in one town than it does in the other to treat this. You know, that's where the true savings lie. Those savings are harder.

Contracting was easy, because you were dealing with large entities, large groups of doctors, large hospital systems. Nowadays

what we're having to do is go out and, in effect, change the way that physicians actually practice. And, I mean, this is a much harder thing for managed care to do.

Ms. NORTON. Do you agree with Mr. Gammarino that prescription costs are the No. 1 factor in driving up health care costs?

Dr. BRAUN. They are certainly a large part. I've got to tell you I got my pharmacy results from the first quarter, and I almost fell over. I mean this is really going to be a very, very expensive year for that.

Ms. NORTON. Dr. Braun, let me just ask you. At one point—one can understand and nobody here is going to be soft on the pharmaceuticals—but at what point are we going to see what is surely the case that some of these drugs are a tradeoff for the kinds of procedures physicians were doing, which are themselves far more costly than putting somebody on medicine.

Dr. BRAUN. Well, yes, ma'am.

Ms. NORTON. As long as you can say it's them, not us, then, of course, we can expect that there's just no tradeoff there, but that also defies common sense.

Dr. BRAUN. I've got to say that the pharmaceutical companies have brought along some miraculous new classes of drugs. I remember when I first started practicing medicine, the treatment for ulcers was mostly surgery. You would go in and do a very invasive procedure. Nowadays we have medications that it is very unusual to have to do a procedure for ulcers and we now treat pharmacologically.

Another example would be some of the newer generation of antibiotics that come along. There are medications like Proscar that can be used as an alternative to prostate surgery.

I mean, we've done a lot of pharmaceuticals. There's a lot more out there that is going to happen. I mean, there's some wonderful new technologies that are going to be coming along in genetics.

The medicines that we have nowadays certainly do more. It has been miraculous, what's happened.

Ms. NORTON. Don't they ultimately cost less than doing invasive procedures?

Dr. BRAUN. The medications, you mean?

Ms. NORTON. Yes.

Dr. BRAUN. Sometimes, yes, on a time-related average, they do. The fact is, though, as there is a pressure in the fact that the aging population there are more chronic diseases out there, too.

One of the big pushes by the pharmaceutical industry recently have been medications and things like arthritis. We are doing a really good job of keeping people alive, but as they get older unfortunately a disease changes from a pattern of acute diseases to one of chronic diseases. You start getting things like heart failure problems, arthritis, diseases that require constant maintenance, constant medications.

These are things that are not very amenable to surgery, unfortunately, at least at this point. So they do require expenditures of the medications and, you know, for many people, some of these medications really are lifestyle changing medications because it allows them to go back to work, you know, do their activities of daily living where they couldn't do them before because of the disease.

Ms. NORTON. Thank you very much.

I see my time is up.

Mrs. MORELLA. Thank you, Congresswoman Norton.

I hope you haven't answered this before; and if you have, just tell me. The patient's bill of rights that we had before us in the last Congress, right now there are probably three bills that are pending on the House side. There has been an attempt to try to change some of the patient's bill of rights the last time and to put it into something else.

I know Mr. Ganske has got a bill and Mr. Norwood and probably Mr. Dingell. I wonder if you had a chance to look at those versions to tell whether there is one that stands out as being the most effective and workable recognizing the fact that we are moving toward reform.

Maybe Mr. Braun feels stronger about it. You can be somewhat objective as you look at it, Mr. Gammarino. I wonder if there is one of them that you think stands out or certain elements within a measure.

Mr. GAMMARINO. I haven't read each one individually so I can't comment on that.

I did address Mr. Mica's question. I don't know if you were in the room then in terms of the difference between what OPM was trying to do and what was up on the Hill. I did caution that in our estimation, we do have to be very careful between what is up on the Hill and the very soft way OPM has implemented these so-called patient bill of rights, at least the framework of it.

That is my primary observation. In terms of which one is better than the other, I think generally we should be very cautious that we don't have unintended consequences that would actually reduce access for enrollees, which none of us wants.

Dr. BRAUN. Again, I have to echo Mr. Gammarino's comments. I have read them to some degree, but my concern with all of them is the same and this has been alluded to by many of the witnesses here and also members of the panel.

When you add administrative costs to a program, there is only a certain amount of money that goes around them. When you start spending things on administrative things, my concern is that there won't be enough money that will actually reach down and help treat the patient.

I mean, as we have talked about before, there are increasing pressures from things like pharmaceuticals and technology and like that. There is more demand for the health-care dollar. We want to be spending that on the patients and not on the administrative things.

Ms. NORTON. Would the gentlelady yield for a question on that?

Mrs. MORELLA. Yes.

Ms. NORTON. Mr. Braun, haven't some of your health plan plans voluntarily adopted——

Dr. BRAUN. Yes, ma'am. Many of the provisions we totally agree with.

Ms. NORTON. Haven't some of them been adopted in total, the patient's bills of rights?

Dr. BRAUN. I don't know if in total. I know many of the provisions have been voluntarily adopted. Most of the health care plans

nowadays—I worked for some of the big ones. I worked for NYLCare which is now Aetna. I worked for Pacific care. I worked for United.

I came up to George Washington University because it is a not-for-profit health plan. I feel that there is really a great deal to be done with managed care. Where simply a way points along the way as this product evolves, and I certainly hope we have the freedom to evolve this into a program where there really is active medical consumers. I mean, one of the things I pride myself at GW is we try to get the individual members involved. I would say that even the bigger companies are trying to do that more and more, get the health care consumer involved in understanding what the costs are.

This has been one of the problems. We have isolated the consumer basically from what the true costs of medical care are for years, and they need to have a better understanding and participate in that and be active in it.

Mrs. MORELLA. Thank you.

Mr. Allen, I will defer to you, and I will get back to questioning.

Mr. ALLEN. Thank you, Madam Chair.

Mr. Gammarino, you testified in response to a question from Mr. Mica that flexibility of benefit design, especially with regard to prescription drugs would help lower costs. I would like to ask you about that but first a preliminary question. Can you tell me whether or not Blue Cross gets a system-wide price for the various drugs that it orders or buys from the manufacturers?

Mr. GAMMARINO. No, it does not. Blue Cross Blue Shield is made up of individual corporations. They negotiate separately. However, for the Blue Cross Blue Shield Federal Employee Program, which I manage for all the Blue Cross Blue Shield plans, we do negotiate on behalf of the plans for this particular program. So we do get specific discounts that are passed on to the program that we are allowed to negotiate.

Mr. ALLEN. Now, I suspect in trying to think about flexibility of benefit design and how it operates that you have got at least three factors, correct me if I am wrong, that relate to this issue. First, there is a cost. How much you pay the manufacturer for particular drugs. Second, there is a level of premium. How much you are being paid overall and a certain percentage of that is going to obviously go for prescription drug coverage and third, the need of the plan beneficiaries. I mean, how many drugs and what kinds of drugs do they need.

I know that is not technical. That is not a technical analysis but correct that if that is wrong but then my question is—the fundamental question is how would flexibility of benefit design lower the cost of prescription drugs and for whom? Members of the plan, others or so forth?

Mr. GAMMARINO. That is a good question. It would lower the costs in a number of ways. As I have testified before this committee many times, one of our problematic areas is that we have free drugs for a segment of our population. And with the new drugs coming on-line, the price increases and the demand-induced utilization we have through direct consumer advertising from the pharmaceutical industry, the demand for these drugs is quite high.

There is no incentive for the enrollee to be a partner with their physician, their pharmacist to ask the question not only what is best for me but what are the costs relative to what I need. And absent that, we feel there is significant wastage and, in many cases, overutilization without the patient having some financial incentive to be part of the decisionmaking process.

So that is one area of savings that we think would occur. Drugs that are unnecessarily being prescribed would not be or a different drug would be prescribed that could do the same thing, but it is less expensive, like a generic drug.

What are the other savings? Some of them would flow directly to the program in terms of it would cost the subscriber more out of his or her pocket to participate and get that particular drug. Now, why would you want that? Well, we just talked about it. But for years we had an artificial benefit design relative to what consumers paid.

When drugs were—when drugs were on no one's radar screen, when they were 5, 6, 7 percent of our premium dollar, we all had low copays or no copays. Why not provide that level of care? It has changed. And just as we have co-insurance on the physician side, we need ample co-insurance on this side too to make the consumer aware of the real costs associated with this.

Mr. ALLEN. If I could just followup with that. There are lots of plans out there, Medicare, Medigap coverage plans for people on Medicare which are not widely utilized precisely because they have a 50 percent copay, $250 deductible and sometimes a $1,500 or $1,200 cap.

I understand what you are saying basically, if you have a copay, then maybe that will help. I would be inclined to add, maybe a little. But in terms of annual 15 percent increases in costs for pharmaceuticals, it seems to me that there has to be another route. And I am just wondering if there is anything else about benefit design that would help?

Mr. GAMMARINO. Mr. Allen, you are very observant in that regard. What I am saying is the benefit design allows us what we need to start to get back into the game of having the subscriber involved. Is it going to significantly reduce that trend line to a single digit? No, it will not.

And so you are right in that respect. Everybody is fighting the same battle and nobody has figured it out in terms of trying to break that trend line. I am not sure it is going to be broken any time soon. The industry is very innovative. They are producing drugs that people want and, in many cases, need; and there is a significant demand from the American population for that product.

Mr. ALLEN. Just in conclusion, the problem is that, but for a huge number of seniors that cannot afford to take the drugs that their doctors tell them they have to take—and there is a great reluctance in this Congress to do the simplest thing, which is to allow the Federal Government to negotiate on behalf of those seniors, reduce prices for Medicare beneficiaries and that is a simple step that could be taken.

I thank you for your testimony.

Mr. GAMMARINO. You are welcome.

Mr. SCARBOROUGH [presiding]. Mrs. Morella, do you have a followup?

Mrs. MORELLA. Yes, I do. Thank you.

I am going to, later on this afternoon, go to a press conference where Erik Davis the baseball player is going to be and, as you guess, is on colorectal cancer.

I know if you have the colonoscopy every 10 years before the age of 50, that is beneficial in detection, and the screening may be every year after the age of 50.

I wondered if under the FEHB program your plans, Blue Cross and Blue Shield and the GW plan, do you cover that now?

Dr. BRAUN. Ma'am, we take and cover preventive services. We use the standards of the President's National Task Force on Preventive Services.

You know, we have a very active program trying to use screening tests in the most cost efficacious way. When one comes along, we are very quick to take and respond to it and to add it if it does, in fact, show that it is going to be a benefit.

You know, the colon—colorectal thing has come on the screen quite a bit. There is a number of tests that can be done. The hemocults, things like that, that are actually self-participatory by the members themselves. One of the things that we really try to encourage members to do is both preventive and screening, preventive in the sense of making sure they eat a proper diet.

As we know diet is very important but the second part of it is to also engage in conversation with their doctor to make sure they are getting the screening procedures they need, especially if they have a family history.

Mrs. MORELLA. Assuming you would pay for the screening certainly?

Dr. BRAUN. Certainly.

Mrs. MORELLA. And Blue Cross Blue Shield?

Mr. GAMMARINO. Mrs. Morella, we do cover what we call routine physicals and related screenings every 3 years for our enrolled population if they so choose. That specific service, I would have to research that and get back to you.

I would be more than happy to do that.

Mrs. MORELLA. I would be very interested to have that response. I might add that to comments.

Dr. BRAUN. May I say, oftentimes it is not the problem with us covering it or not. It is the reluctance of the patient oftentimes to be involved in this process. I would say again here this is a great place where consumerism and getting the patient involved in a discussion with the physician would be very important.

I mean, you don't see too many people saying, gee, you know, I just turned 50, and I got a birthday present, a colonoscopy. We have to start getting people thinking about this.

Mrs. MORELLA. Right. I think this is something we all can fulfill. You can fulfill. We can too and that is the education part of it, PSAs, public service announcements all working together to let them realize what this can do to help the quality of life, to save money in all ways.

On another issue that deals with a different facet, coverage for hearing aids. Do either of you have coverage for hearing aids? I say

that because I had my open season for Federal employees health benefits and I was amazed.

I had so many people there who were all talking about hearing aid coverage and I have all the statistics, you know, 26 million hard-of-hearing adults under the age of 65, the average cost of a hearing aid, and I am wondering do you cover it? Or do you think about exploring that further? Do you think it would have an impact beneficially, adversely? You want to offer any comments on that?

Mr. GAMMARINO. Mrs. Morella, we, today, do not cover hearing aids. We are evaluating whether or not, with our purchasing power, we could; and it wouldn't be part of our normal benefit design. It would be outside of it, but those people that participate in the FEHBP could enjoy a significant discount that they could have relative to our purchasing power with one or two major vendors in that area. It is not part of our benefit design today.

Dr. BRAUN. Basically that is the same with us. It is kind of in the same category as the vision and the dental. We do have programs where we can get discounts, but at this point it is not designed or it is not in the benefit design that we have given OPM.

Mrs. MORELLA. Mr. Chairman, I would like to, with your permission and permission of the subcommittee, to be able to submit some further questions to our panelists as well as to OPM.

Mr. SCARBOROUGH. Great. Thank you. Hearing no objection, it is so ordered.

And gentlemen, I thank you for coming and testifying with us today. You certainly have been very helpful as we continue to dig into how to best improve our health care system for our Federal employees. For the Members, we are going to take a very brief break, and then we are going to mark up H.R. 457 and H.R. 206. This hearing is adjourned.

[Whereupon, at 12:38 p.m., the subcommittee was adjourned.]

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